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UNIVERSITY OF ALBERTA

Therapists' and Clients' Experiences of Resistance in Long-Term Psychotherapy

BY

Diane Christine Priebe

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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OF MASTER OF EDUCATION

IN

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Dr. B. Paulson (Supervisor)

Dr. D.T. Shannon-Brady

Dr. John Hogg

DATE: September 26, 1995

DEDICATION

I would like to dedicate this work to my family, my partner, and my friends. To my parents, Hans and Ilse, and my sister, Iris, who have given me their unconditional love and support throughout my whole life and have nurtured within me the strength and determination that have carried me through all of my life experiences, including this one.

To Pat, who has been with me through every step of this process, from beginning to end, and with whom I have shared my joy and excitement, as well as my tears and disappointment. Thank you for your love, for listening, and for giving me a shoulder to lean on when I needed it.

To my friends, especially Karen, Jill, and Louise, for believing in me, encouraging me, and keeping things in perspective. You have been true "kindred spirits."

Abstract

This study explored the phenomenon of resistance through the experiences of therapists and clients engaged in long-term psychotherapy. The literature on psychotherapeutic resistance indicated that numerous studies have been conducted, but that few have explored resistance from a phenomenological perspective, and that no studies existed which compared the experiences of both people within a therapeutic relationship. A qualitative, phenomenological research method was utilized to gather descriptions from four therapist-client pairs, who had been engaged in psychotherapy for at least one year, about their experiences of resistance within a session.

The findings indicated that there were parallels and discrepancies between the thematic descriptions gathered from the two groups of participants. Both therapists and clients highlighted the paradoxical nature of resistance, the significance of an incongruent therapy relationship to the expression of resistance, and the variable of client mastery. Differences between the two groups were that the therapists tended to be outcome-oriented, whereas clients were process-oriented, the groups utilized different language in their descriptions of the phenomenon of resistance, and the clients were more self-focused, whereas the therapists were more other-focused.

The study resulted in the explication of resistance from a new perspective, one derived from the experiences of both therapists and clients. This new perspective describes resistance as a process, something which occurs between two people in the context of a therapeutic relationship and which continually oscillates forward and backward. The common thread derived from therapist and client descriptions of their experiences of resistance is incongruence of the therapeutic relationship and process. Resistance is explained in these terms through the participants' stories and is further compared and contrasted with the current research and clinical literature.

Acknowledgments

I would like to thank the eight people who participated in this study. Thank you for sharing your experiences with me, for giving so generously of your time and energy, and for allowing me to be a part of each of your lives for a brief moment. I hope that through my interpretation of your experiences we may understand more about the process of psychotherapeutic resistance and what meaning it holds for clients and therapists.

I would also like to thank Barbara Paulson, Dustin Shannon-Brady, and John Hogg for their feedback and constructive comments on this thesis.

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Chapter 1: Introduction

The Concept of Resistance.

" . . . Resistance is . . . part of the process of change"

(Ohlsen, Horne, & Lawe, 1988, p. 165).

Resistance is a theoretical concept which has long fascinated psychotherapy researchers. Resistance is also an experiential component of the psychotherapeutic process which has puzzled clinicians working within every major framework of psychotherapy. The complexity of the phenomenon of resistance is both theoretically fascinating and clinically puzzling. Historically, resistance in psychotherapy has been defined as occurring when the client simultaneously desires and impedes change. This definition is, however, deceptively simple. It captures neither the theoretical complexities which exist in the research literature on resistance, nor the clinical nuances experienced by the psychotherapist and the client when they encounter an impasse or blocked process in a session. The research literature has provided a diverse collection of definitions and theories of resistance whereas clinical accounts have attempted to explain both the interactional and the intrapersonal aspects of the experience of resistance in psychotherapy. However, a unified explanation of resistance from either the theoretical or the clinical perspective does not yet exist.

Definitions of Resistance.

Theoretically, resistance has been defined in many different ways. The definitions vary depending on the theoretical postulation of the origin of resistance. The majority of conceptualizations consider resistance as either residing within the client (intrapersonal) or as a product of the therapist or therapeutic relationship (interactional). Theoretical orientation determines how resistance is defined because different schools of psychotherapy have distinct historical roots and patterns of development which have led to different formulations of the causes, nature, and expression of resistance. Psychodynamic and psychoanalytic therapies, for instance, have historically conceptualized resistance as intrapersonal, and as an ever-present, detrimental therapeutic force which is expressed in various forms, most often as the rejection of the therapist's interpretations. According to

this theoretical orientation, "resistance is any action or attitude of the client's that impedes the course of therapeutic work" (Strean, 1985, p. 1).

In contrast, cognitive and behavioral therapies have defined resistance as a function of the therapist's process or of the interactional process between therapist and client. Lazarus and Fay (1990) stated that resistance " . . . does not rest with the patient, but hinges on the methodology of the therapy as well as the skill and personal qualities of the therapist" (p. 41). These therapies embody a more positive perspective of resistance in conceiving of it as a fundamental, essential part of the therapy process: " . . . resistance is a natural and often necessary concomitant of the change process and should be worked with, rather than opposed" (Dowd & Seibel, 1990, pp. 458-459).

The focus on resistance as either an intrapersonal or an interpersonal process is a significant distinction which differentiates the theoretical definitions from the major schools of psychotherapy. This distinction has been expressed in various ways, such as trait versus state resistance (Otani, 1989a), patient-centered versus therapist-centered resistance (Bauer & Mills, 1989), resistance versus counterresistance (Bernstein & Landaiche, 1992), and transferential resistance versus realistic resistance (Rennie, 1994). This theoretical division in the definition of resistance as originating from either a client-locus or a therapist/therapy-locus has created much of the confusion among both researchers and clinicians. A clear, coherent conceptualization of the construct and experience of resistance is vital for understanding the process of psychotherapy and for determining the future direction of research and clinical work.

Clinically, resistance has been defined in even more diverse ways than it has theoretically. Most of these definitions have focused on the client-locus variables of resistance. Resistance is interpreted within the context of both explicit and implicit client factors. It " . . . consists of a set of verbal and nonverbal behaviors that mediate counseling outcome and process" (Otani, 1989a). Thus, resistance is conceptualized as both the commission and omission of certain behaviors in therapy. In addition, resistance is inferred from the client's attitude towards the therapy session, the therapeutic process, and the therapist.

Client behaviors, which have been interpreted as resistant, can be classified into a variety of taxonomies. Higgs (1992) classified as resistant such behaviors as laughter, excessive talking, monopolizing, intellectualizing, and generalizing. In terms of verbal resistances, Ormont (1988) defined client behaviors such as fact seeking, fault finding, fighting, setting conditions for closeness, and diverting. Chamberlain, Patterson, Reid, Kavanagh, and Forgatch (1984) classified resistant responses in their Client Resistance Code as interrupt/talkover, challenge/confront, and not tracking. Other client behaviors, such as silence, are also interpreted and classified as resistance (Higgs, 1992; Otani, 1989).

Client attitudinal variables which have been classified as resistant include: self-absorption, detachment, dissatisfaction, distrust, compliance (Ormont, 1988); negative attitude and own agenda (Chamberlain, et al., 1984); and "logistic management resistance", such as poor appointment keeping, payment delay/refusal, and personal favor-asking (Otani, 1989).

The literature contains several descriptions of resistance which focus on the therapist/therapy-locus variables. Bauer and Mills (1989) classify "therapist-centered resistance" into the following categories: avoidance of here-and-now affect, overemphasis on genetic investigation, limited therapist activity, difficulties in differentiating transference from nontransference behavior, presentation of a posture of certainty, and premature interpretation of patient projections. Another classification distinguishes three categories of counsellor determinants of client resistance: counsellor expectations and demands, counsellor-imposed client roles, and counsellor-enhanced belief in "client resistance" (Mahrer, Murphy, Gagnon, & Gingras, 1994). Lewis and Evans (1986) define three therapist assumptions which underlie the occurrence of resistance: competent therapist functioning, therapist knowledge of client material which should not be discussed at a given point in the therapy process, and therapist identification of adequate client progress.

Implications of Resistance for Psychotherapy.

Given a rudimentary understanding and conceptualization of resistance, one consequently wonders whether the theoretical construct or the experiential phenomenon of resistance is important to psychotherapy. Some authors have argued that resistance is an insignificant process and a detrimental concept within psychotherapy: "a concept of 'resistance' within this framework would hinder and handicap the therapist because it implies that change is not inevitable, setting up a contest between changing and nonchanging" (de Shazer, 1984, pp. 16-17). From this perspective, resistance is a concept which has outlived its usefulness because it focuses on negative forces, which run counter to the change process. De Shazer (1989) maintains that "as therapists, we do not need an explanatory metaphor dealing with non-change or resistance to change . . . according to clients and various theories, things seem to not change with little or no help from anyone" (p. 228).

While this view has merit with respect to highlighting the non-productive or maladaptive functions of the theoretical aspects of this concept, resistance remains both a fascinating and a baffling phenomenon for clinicians and researchers alike. The experience of resistance in psychotherapy merits further exploration and study because the goal of psychotherapy is change, whereas the reality of the psychotherapeutic process is that often change is not an ongoing occurrence. Every clinician has undoubtedly experienced moments during which the process of psychotherapy seems to be "stuck", not moving forward or progressing. It is these moments in psychotherapy which fascinate and puzzle the clinician and the researcher.

To understand psychotherapy and the change process, it is necessary to comprehend both the forward and the backward movements, like the ebb and the flood of the tides, which are intrinsic to the process of therapeutic change. We also need to understand this process within the interpersonal context of the therapeutic relationship between therapist and client because every occurrence in therapy, including moments of change and of "stuckness", is interactional in nature.

Purpose and Significance of the Study.

The purpose of this study is to examine and compare the client's and the therapist's experience of resistance in psychotherapy. Much of the previous research and thinking about resistance has focused exclusively on the therapist's perspective, in terms of theories, conceptualizations, definitions, and interventions. There exists only very limited research which embodies the client's perspective of this process. One such study is Rennie's (1994) qualitative analysis of clients' experiences of resistance in a counselling session. This study served as the inspiration of the present research in terms of both the particular method utilized and the focus on the client's perspective. The present study aimed to utilize a similar method, in this case a qualitative, phenomenological approach, to the exploration of the experience of resistance. This experience was explored from the perspective of both the client and the therapist.

The Question.

The research question of this study is: What are the "common threads" in therapists' and clients' experiences of the phenomenon of resistance in a psychotherapy session?

Whereas previous studies have accessed one level of information, that is, they have usually focused on the theoretical concept of resistance from either client or therapist perspective, the present study attempted to access a different level of information, that is, it attempted to focus on the experience of resistance from both client and therapist perspectives. The study attempted to move beyond a theoretical conceptualization to access the experience of resistance as a phenomenon within psychotherapy, and it compared this experience from the perspectives of the two people engaged in the psychotherapy process, the client and the therapist. In this way, it was hoped that a richer description and understanding of resistance would be achieved.

Chapter 2: Literature Review

Introduction

Resistance is a pervasive concept and phenomenon found in both the research and clinical psychotherapeutic literature. Resistance is a concept which is debated and discussed, studied and explored, and even refuted as a useful construct in psychotherapy (Breshgold, 1989; de Shazer, 1984, 1989). However, despite these refutations, resistance has a long history as a central theoretical concept and as an experiential phenomenon within the research and practice of psychotherapy.

This survey of the literature on resistance in psychotherapy reflects two general categories of articles which represent both the concept and the experience of resistance: theoretical and clinical. The theoretical articles consist of an examination of the concept of resistance from the perspectives of the major schools of psychotherapy. Since theoretical orientation is the main determinant of how resistance is defined, a theoretical review of the literature is essential for understanding, and then further exploring, this complex phenomenon. The clinical articles consist of quantitative, experimental and qualitative, descriptive studies of the phenomenon of resistance, including its measurement and assessment, and client and therapist perspectives.

Theoretical Perspectives of Resistance

Psychoanalytic

Freud is generally credited for bringing the concept of resistance to the forefront of clinical and research interest in the field of psychotherapy. Resistance was not, however, a new concept when Freud delineated it as a central tenet of his theory of psychoanalysis. In fact, ancient philosophers, including Confucius, Seneca, and Marcus Aurelius, as well as early practitioners of psychotherapy, such as Hippolyte Bernheim, Jean-Martin Charcot, and Pierre Janet, " . . . recognized that people who voluntarily try to alleviate their psychological and behavioral problems often resist their own and their teachers' best efforts" (Ellis, 1985, p. 5). Nevertheless, Freud is often perceived as originally defining the concept of resistance and developing it into a prominent aspect of the process of psychotherapy.

Freud conceived of resistance as an entity within the client's unconscious which blocks the therapist and prevents the treatment in order to protect the client from "the pain of recognizing unbearable ideas" (Strean, 1985, p. 3). Resistance was conceptualized as "violent and tenacious", as acting outside of the client's awareness, and as occurring in a variety of different forms (Freud, 1916/1963). Resistance, according to Freud, was the " . . . opposition, during psychoanalytic treatment . . . against our effort to transform what is unconscious into what is conscious" (Freud, 1916/1963, p. 294).

Subsequently, resistance became a central tenet of psychoanalysis because "it is only in psychoanalytic therapy that . . . [an] attempt [is made] to overcome resistances by analyzing them, by uncovering and interpreting their causes, purposes, modes and histories" (Greenson, 1967, p. 59). The ascendance of resistance within psychoanalysis occurred when Freud abandoned the method of hypnosis in favor of the technique of free association. According to Freud (1916/1963), hypnosis was allowing the client resistances to operate without the analyst's awareness of them. He came to realize that every client makes an attempt at " . . . reserving some region or other for himself [sic] so as to prevent the treatment from having access to it" (Freud, 1916/1963, p. 288).

The technique of free association, however, did not allow "any such right of asylum" (Freud, 1916/1963). Thus, the client, in order to succeed and benefit from psychoanalytic treatment, was to talk about whatever entered the mind, no matter how painful or embarrassing or seemingly irrelevant. When the analyst perceived the client as withholding material, it was labelled as resistance and reflected the deeper, "pathogenic process" of repression. Consequently, in overcoming this resistance, which was "the essential function of analysis" (Freud, 1916/1963, p. 291), the analyst could be assured that something had been accomplished with the client.

During analysis, resistance is perceived in many forms and variations, including chance events which occurred in session, diversions outside of session, comments by authority figures hostile to analysis, client organic illnesses, and client improvements (Freud 1916/1963). Freud classified these many forms of client resistance into five major categories: (a) repression and other defenses, such as projection and denial, (b) transference, (c) epinosic gain (i.e., "secondary gain"), (d) superego resistance, and (e) id

resistance (Strean, 1985). These different categories of resistance can be practically differentiated into ego-syntonic versus ego-alien resistances (Greenson, 1967). The process of analysis begins by converting the resistances into ego-alien resistances so that the patient will work analytically with the analyst (Greenson, 1967).

Psychodynamic

Psychodynamic therapists and writers have continued to explore and expand the concept of resistance, utilizing Freud's formulations as a basis and moving beyond these formulations. Resistance in psychodynamic psychotherapy is conceptualized as the client's mechanism of self-protection from some form of impending danger which is felt during the therapeutic process (Strean, 1985). Defenses used by the client in everyday life, such as protection, denial and repression, are defined as resistances in psychotherapy; these resistances are not created by psychotherapy per se, but rather, therapy stimulates anxiety, and the client utilizes these habitual defenses to oppose the therapist and the therapy (Strean, 1985).

Other psychodynamic writers delineate resistance as "the generic term which encompasses all behavior that seemingly interferes with therapeutic uncovering and understanding" (Singer, 1970, p. 224). Resistance may be subtle or outright, but it may also be "a sign of remarkable well-being" (p. 225) in that the client may be legitimately rejecting the therapist's incorrect or unfounded interpretations (Singer, 1970). This latter point differentiates some of the psychodynamic practitioners from Freud because the analyst, or therapist, is not considered to be an all-knowing, omnipotent "oracle of wisdom" (Singer, 1970; Strean, 1985).

According to Singer (1970), the main difference between the psychoanalytic and psychodynamic definitions of resistance is that Freud conceptualized resistance as a regressive process--through resistance the client achieves a "neurotic compromise" between the pleasure principle and the reality principle--whereas psychodynamic theorists view resistance as a survival mechanism, " . . . as opposition to demands to give up what one realistically considers essential for survival" (p. 234). Thus, the client's maladaptive behaviors are seen as a way of maintaining integrity. From the client's perspective, there are no other alternative behaviors available. The therapist's efforts to investigate and

explore the resistances indicate to the client the conviction that there are alternative ways of behaving, experiencing, and living available (Singer, 1970).

Cognitive and behavioral

There are several different models of resistance within the cognitive and behavioral traditions of psychotherapy, including a cognitive model, a behavioral model, a combined cognitive-behavioral model, a reactance model, and the rational-emotive model. Each of these models have contributed to our understanding of resistance from a cognitive-behavioral perspective.

Resistance was not considered a concept in the original version of behavior therapy (Golden, 1989). Eventually, though, resistance came to be operationally defined as " . . . the failure of the client to comply with the therapeutic procedures" (Golden, 1989, p.4). This adjustment in the theoretical formulation of resistance in behavior therapy occurred because therapists observed that clients did not always comply with homework and other therapy assignments, and thus behavior change was not always achieved as the desired outcome. When the behavior therapist observes the client's failure to comply, he/she can then intervene (Golden, 1989). Other theorists with a behavioral slant claim that resistance is not the result of client functioning at all, but rather is an outcome of the skill and personal qualities of the therapist, as well as how the therapy is conducted (Lazarus & Fay, 1990).

A cognitive perspective of resistance was espoused by some theorists who formulated a theory of cognitive "blocks" to change (Trower & Dryden, 1989). These blocks were seen as "cognitive . . . roadblocks on a journey to achieve desired goals" (p. 132). Thus, maladaptive cognitions, operating in self-fulfilling cycles, were conceptualized as being at the root of dysfunctional emotions, such as depression, and self-defeating behaviors, such as avoidance and giving up (Trower & Dryden, 1989).

Cognitive-behavioral approaches to resistance combine some of the facets of the previous two models, in that they consider both cognitive factors and behavioral patterns which together can result in resistance in therapy (Golden, 1989). These approaches view the full spectrum of potential sources of resistance in psychotherapy by taking into account therapy and therapist factors, environmental and external factors, and factors

operating within the client (Golden, 1989). The cognitive-behavioral therapies emphasize a direct approach to resistance which " . . . includes looking for self-defeating cognitions, hidden agendas, motivational problems, higher-order anxieties, and reinforcing consequences" (Golden, 1989, p. 6). Thus, the focus in cognitive-behavioral therapy is on identifying the resistance, exploring it with the client on all applicable levels, and then problem-solving to resolve the resistance and continue the therapy work. Another author has defined it as an information-processing model wherein "individuals are reluctant to consider data that appear to contradict a firmly entrenched theory and thus selectively screen out disconfirming data" (Dowd, 1989, p. 145).

Dowd (1989) and Dowd and Seibel (1990) have posited a model of reactance which represents a person-situation interaction (for example, client-therapy) and is motivational in nature. This model is different from resistance, which represents specific client actions in a specific situation, because it is " . . . an internal motivational state that can be aroused by characteristics of both the situation and the individual" (Dowd, 1989, p. 142). Dowd's model of reactance is based on the work of Brehm and Brehm (1981) who developed a theory of psychological reactance in which people see themselves as possessing free behaviors in which they can engage. Psychological reactance is aroused when these free behaviors are eliminated or threatened with elimination. Thus, this model emphasizes the importance of personal control in people's lives, which is an especially strong, compelling force in our western civilization (Dowd & Seibel, 1990). Reactance is characterological and functions to create and maintain the individual's autonomy (Dowd & Seibel, 1990).

The rational-emotive therapy of Albert Ellis (1985) conceptualizes resistance within the framework of his "A-B-C" paradigm. Within the context of this paradigm, an activating event, ("A"), leads to the formulation of rational beliefs ("rB's") about the activating event, ("B"), which results in a consequence, ("C"), either emotional or behavioral. In terms of resistance in psychotherapy, the sequence would occur as follows: the client experiences the therapist's interpretations ("A"), then tells him/herself rational beliefs about those interpretations, such as that the therapist is wrong, ("B"), which results in the client resisting the therapist's interpretations ("C"). Rational-emotive therapy thus

defines the occurrence of resistance " . . . when clients self defeatingly and irrationally resist following therapeutic procedures and homework assignments, they largely do so because of their explicit and implicit cognitions or beliefs" (Ellis, 1986, p. 267).

Ellis (1985) delineates five major categories of resistance within the rational-emotive therapy framework. These categories are: healthy and normal resistance, resistance resulting from severe disturbance, usual noncompliance or resistance, resistance connected with therapist-client relationships, and environmental factors that lead to resistance. The category of usual noncompliance includes ten sub-categories, some of which are: resistance created by fear of discomfort, fear of disclosure and shame, resistance stemming from feelings of hopelessness, and resistance motivated by fear of change or success.

In addition to considering client and relationship factors which contribute to resistance, Ellis (1985) is interested in therapist factors which lead to resistance in therapy. He has written an entire chapter on this topic, entitled "How to deal with your most difficult client--You", which outlines personal, interpersonal and professional issues which can lead the therapist to resist the client's process within therapy.

Humanistic

The humanistic approaches to psychotherapy, for example, Carl Rogers' client-centered therapy, do not address the concept of resistance directly. Instead, they attempt to focus on the positive aspects of the client's change process and the facilitation of this process by the prescription of a supportive and accepting role for the therapist. Rogers (1951) believed in the "forward-moving forces of life itself" (p. 195). Rogers emphasized that humans possess a basic tendency towards the maintenance and enhancement of the self, which can be nurtured and expanded in the therapy setting, given the appropriate conditions.

The three basic conditions which Rogers (1961) deemed necessary to facilitate the client's psychological growth are: therapist congruence with the client, therapist unconditional positive regard for the client, and therapist empathic understanding. Thus, Rogers (1961) felt that "if I can provide a certain type of relationship, the other person will discover within himself [sic] the capacity to use that relationship for growth, and

change and personal development will occur" (p. 33). Rogers (1961) claimed that when these conditions were present, and the client could experience them to some degree, change would invariably occur.

The closest that Rogers (1951) came to addressing resistance was in his description of the therapeutic process, in which the client becomes aware of experiences which are contradictory to the perception of the self. This situation leads to the client feeling threatened, thus temporarily retreating to a more "comfortable gestalt", from which he/she attempts to assimilate the new experiences (Rogers, 1951, p. 193).

Gestalt therapy

Gestalt therapy is unlike most other psychotherapies, which desire behavior change, in that its goal is to restore the client's lost awareness, both self-awareness and awareness of the external, social world (Perls, 1947). Perls (1951) regarded this lost awareness as resulting from an originally creative adjustment which served to accommodate an early conflict between the needs of the person and the requirements of the environment (Perls, 1947).

In terms of resistance, Gestalt therapy takes " . . . an approach to working with resistance . . . which frames resistance as a necessary aspect of human functioning that carries with it both self-protective and self-limiting aspects" (Cole, 1994, p. 71). Perls (1951) postulated that a therapist may perceive the client's apparent inability to see and change the presenting problem as resistance, whereas this inability is actually due to the client's lost or disturbed awareness. It is part of the client's "unfinished business" which he/she is attempting to work out.

Thus, the Gestalt therapist should accept the validity of the resistance because this force is as much a part of the client as the part which has come to therapy to solve problems (Perls, 1951). The way to deal with the resistances, according to Perls (1951), was to encourage, heighten, and explore them, in all aspects, including intellectual, emotional, and bodily, in order to understand their purpose and meaning.

Other theorists have rejected the concept of resistance as unsuitable to the approach and philosophy of Gestalt therapy (Polster & Polster, 1976). Breshgold (1989) elaborates that resistance is unnecessary as a concept because Gestalt therapy endorses

phenomenology (awareness), a horizontal, non-hierarchical relationship between therapist and client, and a dynamic, interrelated process between all things.

Systemic/Strategic

Systemic and family therapies tend to view resistance positively and consider the entire therapeutic system, including external influences from the clinician and from family patterns (Basham, 1992). Resistance occurs when the system, whether this is an individual or a family, attempts to maintain the status quo in response to attempts at change coming from the therapist (de Shazer, 1984). These therapies perceive clients as entering psychotherapy in a reactive mode, that is, clients are experiencing difficulties adapting to change and they have come to therapy looking for new solutions (Basham, 1992). Resistance is an adaptive process which allows clients to retain "homeostasis" and a sense of familiarity within a context of change (de Shazer, 1984). Thus, systemic therapies emphasize the reciprocity of behavior, that each person within a system affects other people and vice versa, and the importance of the stability of the system.

Systems theory endorses a blame-free approach to psychotherapy and the concept of resistance; as one author so aptly stated, "it is important that counselors not blame clients for resisting; rather . . . we should assume that the counselor has failed to provide the proper conditions for helping people change" (Ohlsen, Horne, & Lawe, 1988, p. 166). Similarly, other theorists have conceptualized resistance as the client's own way of participating or "cooperating" with the therapist and the therapeutic process (de Shazer, 1984, 1989; Woody, 1990).

The strategic approach to resistance was influenced and shaped by the ideas of Milton Erickson. Erickson's psychotherapeutic approach focused on the client's symptoms and problems in order to find details about the impact and context of these symptoms so as to discover leverage for changing them (Haley, 1981). The process of change, Erickson believed, could occur quickly by tapping the unconscious mind's innate wisdom and ability to problem-solve (Nichols & Schwartz, 1995). The therapist's role was to take responsibility for the activation of change, including the bypassing of resistance. Thus, Erickson (1964) perceived resistance as a vital communication from the client to the therapist. This communication should be heard, accepted and utilized by the therapist.

Other hypnotically-oriented theorists have commented that resistance is a message from the client's unconscious which determines whether the therapist is respectful of the client's needs (Diamond, 1986).

Building on Erickson's therapeutic foundation, strategic therapists advocate the use of the therapeutic resistance, either by reframing it or resolving it through paradoxical interventions (Laclave & Brack, 1989; Watzlawick, Weakland, & Fisch, 1974). Reframing "changes the way a problem is classified" (Laclave & Brack, 1989), so that resistance may be defined as the client's re-directing the therapist to proceed more congruently with the client's process, rather than as the client impeding the therapist or the therapy. Paradoxical interventions place the client in a positive double bind which forces him/her to perceive the problem in a different perspective (Lawson, 1986).

The focus of these strategic interventions is to encourage "second-order change", which means that the "client's view of the problem is implicitly challenged, necessitating a change in the system itself" (Lawson, 1986, p. 88). Resistance is thus viewed as a necessary and useful aspect of therapy by these approaches; it is "an important vehicle of change" (Watzlawick, Weakland, & Fisch, 1974).

Narrative therapy (Constructivism)

The narrative therapies have been influenced by the constructivist branch of philosophy, which views resistance as either an unnecessary concept (de Shazer, 1984, 1989) or as serving a healthy self-protective function for the client (Mahoney, 1991). The basis of this philosophical position is that reality does not exist in and of itself, but, rather, is constructed by its observer, or, in the case of psychotherapy, is co-constructed by both therapist and client (Nichols & Schwartz, 1995). Thus, resistance is not a phenomenon which exists "out there", although it may be evidenced within the therapeutic relationship.

The self-protective theory of resistance, as formulated by some constructivist authors (see Mahoney, 1991), postulates that resistance is a natural phenomenon which operates to slow the process of change in order to protect the client from change which is incongruent in terms of its nature or pace. Resistance, therefore, serves as clients' " . . . healthy caution about embarking upon or embracing experiences that challenge their integrity, coherence, or (felt) viability as a living system" (Mahoney, 1991, p. 329).

Another model of constructivism was developed by Liotti (1989) within the framework of cognitive psychotherapy. Utilizing a constructivist metapsychology, Liotti claims that individuals have their own structures of meaning, and that these will resist change, especially those structures which are meaningful and central to the person. Cognitive schemata are the templates against which incoming information is matched, preserving the previously stored information (Liotti, 1989). Thus, Liotti claims that opposition and resistance to new information in psychotherapy is part of the normal activity of cognitive processes, and that the "preservation of meaning" is at the core of the explanation of therapeutic resistance (Liotti, 1989, p. 32).

The theoretical perspective of resistance verifies the influence of theoretical model on the definition of this concept. There exists a full range of conceptualizations of resistance, from the psychoanalytic view that resistance is a negative force within the client to be worked through and resolved, to the humanistic and narrative approaches which do not frame resistance as a central tenet of psychotherapy but, rather, emphasize the importance of a supportive, collaborative relationship between therapist and client. In between these two ends of the continuum lie various theoretical models which accept resistance as a main tenet of psychotherapy to different degrees and utilize it accordingly within the psychotherapeutic framework.

Clinical Perspectives of Resistance

The measurement and assessment of resistance

There have been many research studies which have attempted to measure the concept of resistance in psychotherapy. These studies have most often focused on assessing the client's resistance through the development of a scale or checklist. The studies have been conducted within various theoretical frameworks and have manipulated different variables, such as client perceptions and expectations, therapist response mode, and outcome.

Schuller, Crits-Christoph, & Connolly (1991) conducted a research study in order to measure the type and quantity of resistance in dynamic psychotherapy. They developed the Resistance Scale, a 19-item rating scale, which assesses the frequency and intensity of a variety of patient behaviors seen as indicative of resistance in psychoanalysis and

psychoanalytic psychotherapy. The authors concluded that resistance is a multidimensional construct, of which the oppositional dimension was less prominent than its other dimensions. In addition, much of the scale variance was found to result from fluctuations within a session and individual differences between patients.

Mahalik (1994) developed the Client Resistance Scale, whose five subscales are based on R.R. Greenson's (1967) formulation of client resistance. In this formulation, resistance is conceptualized as opposition, which results in the following five subscales: opposing expression of painful affect, opposing recollection of material, opposing the therapist, opposing change, and opposing insight. The purpose of this study was to examine the psychometric properties of this scale and to explore how client resistance manifests itself as a result of client, therapist and therapist response mode variables. Raters utilized the Client Resistance Scale and a measure of therapist response mode to assess two clients in sessions with six expert therapists (i.e., the clients were "Gloria", interviewed by Rogers, Perls, and Ellis, in the film Three Approaches to Psychotherapy, and "Richard, interviewed by Meichenbaum, Beck, and Strupp, in the film Three Approaches to Psychotherapy III).

Mahalik (1994) found that the five subscales on the Client Resistance Scale were highly related, indicating that this particular scale is measuring a unidimensional construct. The subscales were, however, differentially affected by the client, therapist, and therapist response mode variables, indicating that therapists influenced the type and degree of resistance manifested by clients in session. The most effective therapist response modes were found to be interpretation, open question, and minimal encourager; the least effective response mode was closed question.

Verhulst and van de Vijver (1990) conducted a research study which compared the conceptualization of resistance from the perspectives of psychoanalytic and behavior therapists. Resistance was represented in the form of a stimulus-response inventory on questionnaires sent to both types of therapists. The stimulus situations presented in the questionnaires consisted of a short description of a case, a description of the therapeutic context in which the therapy session took place, a description of the "trigger", and a list of 57 verbs from the first pilot study (i.e., the responses of the SR-inventory). The factors

which were systematically varied were the general context of therapy and the interventions of the therapist which preceded resistant behavior from the client (the "triggers").

The results of the study indicated that both behavior and psychoanalytic therapists attach the same meaning to the concept of resistance and that both groups find the concept to be useful. Another finding indicated that the identification of resistance was influenced by the behavior of both the client and the therapist, the situation that gave rise to the resistance, and the interaction between these factors. There were also large individual differences in the meaning which therapists attached to the concept of resistance, and each client behavior was not equally likely to be considered a sign of resistance. Finally, problem-oriented, as opposed to emotion-oriented, therapist interventions tended to trigger resistance in the client.

Chamberlain, Patterson, Reid, Kavanagh, and Forgatch (1984) conducted a study to examine the utility and construct validity of the Client Resistance Code. Using this Code, each client response to a therapist verbalization was rated as being either cooperative or resistant, resistant being classified as client statements which blocked or impeded the therapist's efforts towards change. Resistance was measured at the beginning, middle, and end of treatment. Higher resistance was hypothesized for clients who dropped out of treatment prematurely and for clients who were agency-referred, as opposed to self-referred, because the premature dropouts were seen as not being able to overcome the resistance and thus accomplish change, whereas the agency-referred clients were seen as being pressured to enter therapy, thus laying the groundwork for resistance.

The Client Resistance Code consists of seven categories, of which five assess resistant behavior and two assess cooperative behavior. The five resistant categories, interrupt/talkover, negative attitude, challenge/confront, own agenda, and not tracking, were combined into one category representing client resistance, and the two cooperative categories, nonresistance and facilitative, were combined into another category representing client cooperation.

The authors found that client resistance can be reliably coded at a molecular level using a direct observational system, such as the Client Resistance Code. Modest relationships, as hypothesized, were found between rates of observation of client

resistance and phase of treatment, dropouts versus completers, and referral source. There was also a relationship between the observation of client resistance and the therapist's rating of outcome of treatment.

Paradise and Wilder (1979) conducted a study to examine the relationship between client reluctance and outcome measures of self-reported counselling effectiveness. In this study, client reluctance was assessed by a seven-point rating scale derived from responses to the Mooney Problem Checklist, on which low scores indicated minimum reluctance and high scores indicated maximum reluctance. The Counseling Service Assessment Blank was utilized to assess client-perceived improvement and satisfaction.

This study showed that the greater the degree of pre-counselling reluctance, the less the improvement in the client's problem areas and the less the satisfaction with the counselling experience and the individual counsellor. The type of client problem, vocational or personal, did not affect either the pre-counselling reluctance or post-counselling improvement and satisfaction measures. In addition, clients whose perception of the emphasis of the agency's services matched their problem type (congruent) were significantly less reluctant than clients whose perception did not match (incongruent). Lastly, the greater the pre-counselling reluctance, the greater the likelihood that a client would prematurely terminate.

Seligman and Gaaserud (1994) reviewed the literature on resistance and developed a survey which would elicit counsellors' reactions to and experiences with resistant clients, including their conceptions of resistance, the types of resistance they have encountered, the ways in which they have coped with resistance, and their own responses to resistance. Counsellors were also asked to provide a profile of the most resistant client whom they have counselled.

The responses to the questionnaire indicated that counsellors generally viewed resistance from a broad, atheoretical perspective and as a way for clients to protect themselves from anxiety or guilt. Most counsellors emphasized the importance of the therapeutic relationship and timing to the manifestation and extent of resistance.

Seligman and Gaaserud (1994) classified resistance into five categories in order to obtain information from counsellors on how resistance most likely presented itself. The

five categories are: withholding communication, manipulation, restricting content, violating rules, and hostility. The results indicated that restricting content was the type of resistance encountered most frequently by counsellors. In general, counsellors reported encountering passive forms of resistance more often than they did aggressive forms of resistance.

The most common form of counsellor reaction to resistance on the survey was frustration and feeling challenged. The techniques most frequently utilized by counsellors to address resistance were empathy, confrontation, reframing, and self-disclosure. The authors note that the three most common forms of dealing with resistance are very different in nature, thus reflecting a lack of consensus on the one best way to address resistance in therapy. Profiles of counsellors' most resistant clients indicated a variety of characterizations and descriptions which yielded no specific information on one "most resistant" personality type.

In summarizing the literature on the assessment and measurement of resistance, it is evident that one unified and coherent measure of resistance does not as yet exist. The research findings in this area indicate that there is still much contradiction about the nature and identification of resistance. Some studies have concluded that it is a multidimensional construct, others have found it to be a unidimensional one. While most of the studies have concentrated on measuring "client resistance", some of the findings have indicated that resistance is influenced by the therapist, whereas others have found it to be influenced by the therapist, the client, and the interaction of these variables with the situation. In addition, there seems to be a great deal of diversity in identifying which client behaviors or actions are labelled as resistant, and the techniques which therapists cite in dealing with this resistance.

The research studies do seem, however, to agree on several points. Most therapists identify passive forms of resistance as occurring more frequently than active forms. There also seems to be an identifiable relationship between the degree of resistance and the phase of treatment, with more resistance occurring during the difficult therapy work mid-treatment, and between resistance and treatment outcome, with less resistant clients staying in treatment longer and improving to a greater extent than more resistant clients.

Client perspectives

Though the research literature is replete with quantitative studies which attempt to measure the concept of client resistance from the therapist's perspective, there are very few studies which explore the client's perspective and experience of resistance in psychotherapy. One researcher who has conducted several such studies within a qualitative, descriptive framework is D.L. Rennie (1990, 1992, 1994).

In the most recent of these studies, Rennie (1994) examined clients' moment-to-moment experience of resistance in a counselling session, utilizing a grounded theory form of qualitative analysis. The clients' reports of their experience were stimulated, immediately after a counselling session, by listening to the replay of either an audiotape or a videotape of the session. These reports were transcribed and analyzed, resulting in 51 categories which depict the client's overall experience of counselling. One of the categories is entitled "Resistance by Client".

The results of this study indicated that this category was divisible into three types: resistance to a particular counsellor intervention within the context of a good working alliance; resistance to the counsellor's strategy in the session within the context of a good working alliance; and, resistance to aspects of the counsellor's general approach to counselling the client, in the context of a conflicted working alliance. This study focused on three clients who experienced the latter type of resistance periodically throughout their session. The analysis of their accounts resulted in the conceptualization of their resistance in terms of five aspects: expectancies about the particular counselling session; management of concerns arising from expectancies about the session; power struggles over the best plan for counselling; deference to the counsellor's authority; and, clients' judgments about whether or not they would act on demands arising in the session.

Rennie (1994) summarized these findings as indicating that all clients had definite views on the best plan for counselling, and that clients were often influencing the counsellor while supposedly being influenced by the counsellor. He concludes that " . . . the main implication of the study would seem to be the light it sheds on the importance of being sensitive and open to the client's thoughts about the best approach to treatment" (Rennie, 1994, p. 55).

In another study on the client's general experience of psychotherapy, utilizing the same research method as above, Rennie (1992) elaborates on the core category of meaning which he has formulated from the research to date, namely, client's reflexivity. This reflexivity is defined as the "clients' monitoring and evaluation of thinking and feeling . . . their enactment of thinking and behavior in response to that monitoring, and . . . their construction of personal narratives" (Rennie, 1990, p. 159). He explores this reflexivity in terms of the "covert world" of the client and in terms of therapeutic change (Rennie, 1990, 1992).

In terms of this "covert world" of the client, Rennie (1990, 1992) claims that when clients feel comfortable with their experience and with the therapist, they may say uninhibitedly whatever they are thinking. When there is discomfort in self-experiencing or in the experience of the therapeutic relationship, however, clients must decide whether to say everything which they are thinking in the moment.

In terms of therapeutic change, Rennie (1992) discusses the importance of reflexivity as a "safety zone", that is, as the moment when intentional thought is formed, before it can be acted upon. Rennie (1992) emphasizes the importance of the client's prerogative in this crucial moment: "it is in the indeterminacy of reflexivity that the individual has choices, and hence the possibility of control over change" (p. 227-228). Rennie sees the therapist's role in this moment of indeterminacy as being able to detect it and aid the client in resolving it.

These research findings on the client variables in psychotherapy indicate that valuable information can be gathered from the client's perspective and experience of resistance in therapy. While only the tip of the iceberg in this area has been researched to date, these findings demonstrate that there may be much more occurring during the process of resistance than has been previously explored. Because most of the studies in the area of resistance have focused on the therapist's perspective, many of the research results from Rennie's studies have never been tapped, including the elucidation of the client's "covert world" and the function of resistance as a "safety zone", a moment of decision about how much to reveal to the therapist during a psychotherapy session.

Therapist perspectives

The last aspect of the research literature which is explored in this review is those research studies which focus on the relationship between therapist factors, such as interventions, communication styles and behaviors, and client resistance. These studies are generally interested in the effects of these therapist variables on the client's resistance in psychotherapy.

Allgood, Bischoff, Smith, and Salts (1992) examined clients' responses to therapist interventions used in the structural and strategic therapies that have traditionally been associated with using or decreasing client resistance. The authors hypothesized that the structural and strategic interventions which used client resistance would be associated with higher client resistance, whereas those interventions which reduced client resistance would be associated with lower client resistance. Therapist interventions were rated utilizing a list of 36 techniques frequently used by various models of family therapy. Client resistance was assessed utilizing the Client Resistance Code (Chamberlain, Patterson, Reid, Kavanagh, & Forgatch, 1984).

Allgood et al. (1992) found that, as predicted, the interventions designed to use client resistance were associated with higher client resistance. Contrary to their hypothesis, however, the interventions designed to reduce client resistance were associated with the highest total resistance ratios. The authors attributed these discrepant findings with the type of therapy utilized in this study, that is, couples therapy, and some interactions between client and therapy variables.

Bisese (1990) conducted an analogue study in which two therapist communication styles, engaged/disengaged and collaborative/unidirectional, were covaried with three areas of communication loci, past, current, and transference, to determine their relationship with client resistant or resonant responses. The author hypothesized that a disengaged style of therapist communication, which is neither emotional nor judgmental and focuses on something beyond what the client has overtly stated, is directly related to resonant patient responses, whereas an engaged style of therapist communication, which has emotional involvement and focuses on the same content as expressed by the client, is directly related to resistant patient responses. Similarly, a collaborative therapist style was

expected to elicit resonant client responses, and a unidirectional style was expected to elicit resistant client responses. Lastly, the author investigated differential resistance as a function of the loci of relationships (past, current, and transference).

The findings of this study were equivocal in terms of the author's initial hypotheses. The hypothesis regarding unidirectional versus collaborative therapist style was confirmed as more subjects chose the resistant responses in relation to the unidirectional style than to the collaborative style. The hypothesis regarding disengaged versus engaged therapist style was disconfirmed by the results because more subjects chose the resistant responses in relation to the disengaged style than to the collaborative style. An analysis of the data with respect to loci of relationship showed that the majority of resistant choices were made in the past and current loci, but not in the transference locus.

Mahrer, Murphy, Gagnon, and Gingras (1994) examined counsellor determinants of client resistance in a theoretical article. They formulated three categories of counsellor determinants: counsellor expectations and demands, counsellor-imposed client roles, and counsellor-enhanced belief in "client resistance". The first category consists of the counsellor's explicit or implicit demands for certain specified client behavior: "what the counsellor wants may be called treatment plans or counselling goals, but when the client does not enthusiastically share the counsellor's plans and goals, that may be called resistance" (Mahrer et al., 1994, p. 126).

The second category encompasses the dynamics which can occur in the counselling relationship when the counsellor assigns a certain role to the client which the client does not want to accommodate. This process may result in a power struggle in which the counsellor is "in charge" of the counselling, an "expert", and the client is to be a compliant "patient".

The third category postulates that it is the counsellor's "entrenched belief" in the concept of resistance as a real entity within counselling that actually causes the resistance to occur. The authors assert that the debate about resistance is a matter of perspective: some therapists see certain client behaviors as resistant, whereas other therapists will view these same behaviors as functional and adaptive.

After developing these categories, Mahrer et al. (1994) then devised several explicit strategies to aid counsellors in "curing" the resistance which they have caused. These strategies include emphasizing client readiness, utilizing a single-session model, and alignment of counsellor and client.

Patterson and Forgatch (1985) conducted two studies which examined the immediate impact of therapist behavior on client noncompliance. Therapist behavior was assessed utilizing the Therapist Behavior Code, and client noncompliance was assessed using the Client Noncompliance Code. Both of these studies provided strong support for the authors' hypothesis that therapist efforts to teach and confront significantly increase the likelihood that the client's immediate reaction will be noncompliance. In addition, therapist behaviors of "support" and "facilitate" resulted in reduced likelihood of client noncompliance.

Kerr, Olson, Claiborn, Bauers-Gruenler, and Paolo (1983) studied the effects of counsellor expertness and attractiveness on overcoming restraining forces, such as opposition and resistance, in counselling. The authors hypothesized that a counsellor in an expert role would produce attitude and behavior change more effectively (i.e., reduce opposition) than the counselor in an attractive role, and that the attractive role would increase positive attitudes toward the counselling process (i.e., reduce resistance) more effectively than the expert role. These hypotheses were tested in an analogue and a field study of career counselling for students. The first hypothesis was supported by the first study, whereas the second study supported both hypotheses.

Ruppel and Kaul (1982) investigated the predictions of social influence theory with respect to client resistance to counsellor influence. In this study, counsellor power base and influence attempt (expert and referent for both) were combined to provide a measure of counsellor congruence/incongruence, in addition to counsellor legitimacy/illegitimacy which was established from a measure of trustworthiness.

The findings of this study indicated that the less trustworthy counsellor elicited significantly lower expectations for client instrumentality than did the more trustworthy counsellor. The trustworthiness variable also interacted with congruence, in that trustworthy counsellors who were incongruent in their influence were judged to be less

influential with the client than those who were congruent. An untrustworthy counsellor utilizing an incongruent attempt encountered less resistance than one using a congruent attempt.

As with the previous two sections of this literature review, the area of therapist perspectives of resistance includes both consistent and inconsistent findings. Several of these studies resulted in findings which were not predicted by the authors, in relation to the specific effects of certain therapist interventions on client resistance. Therapist variables such as trustworthiness, congruence, attractiveness and expertness were investigated and evaluated with respect to their influence on client resistance. The main consistent finding of this research literature is that supportive and emotion-oriented therapist styles seem to decrease client resistance, whereas confrontive, problem-oriented therapist styles seem to increase client resistance.

Implications of the Research Literature for the Present Study

The research literature on the theoretical concept and the clinical experience of resistance, as indicated by this review, is diverse and complex. It contains many studies, some of which support certain findings about resistance, and others which refute these same findings. Researchers have attempted to measure, classify, quantify and describe this construct utilizing a variety of different methods and designs. Yet, in summarizing such an extensive literature, the only conclusion which one can make is that there is no definite conclusion to the question of, what is resistance?

Thus, the present study attempted to approach this difficult question in a different manner. Given the limited contribution of this vast literature to the elucidation of the concept of resistance, it was decided to explore the experience of the phenomenon of resistance, in the hope of generating some broader, more coherent explanation of the nature and expression of resistance in psychotherapy. Since research into the realm of experience demanded a different method of exploration, this study left the arena of quantitative research for that of qualitative research.

Chapter 3: Method

Research Approach

The goal of this research was to explore and compare therapists' and clients' experiences of resistance in a therapy session. With this goal in mind, the research literature was examined to determine how the concept of resistance has been investigated in the past and how it might be investigated in the future to illuminate it in a different light. In essence, I wanted to discover how to investigate the phenomenon of resistance so that an additional perspective could be developed. It seemed that, despite the large number of research articles in the area of resistance, very few, if any, grasped the real essence of this complex, ever-present phenomenon.

Much of the research on resistance has resulted from the quantitative perspective, including some articles which have an exclusively theoretical focus. The quantitative approach to research is synonymous with terms such as objectivity, operational-definition, measurable, observable, and quantifiable. These qualities are intrinsic to this research approach and embody a separation of theory from experience. Quantitative research emphasizes a dualistic view of science, creating a strict boundary between researcher and that which is researched. Thus, the research participant is objectified, and research measures are seen as quantifiable. This boundary and separation is what lends an aura of objectivity to quantitative science, and that which often identifies it as "hard science". Similarly, the theoretical approach to research maintains a distance from the actual experience of the research participants, although it does espouse a more descriptive technique, rather than a strictly experimental one.

Whereas a quantitative approach may be valid for research in some areas, such as physics or mathematics, because their intent is to study physical objects and to subsequently determine cause-effect relationships and laws, this approach is fraught with difficulty when used to research human sciences, in which the goal is to study people, and to determine their experiences on a variety of dimensions. As Colazizzi (1978) has so aptly stated, " . . . just as we implicitly expect and accept a great distance between theory and experience in natural science, we implicitly recognize and demand a closer tie-in between theory and experience in psychological inquiry" (p. 49).

A research method which provi. 's an alternative to the quantitative tradition of experimental methodology is qualitative research. Qualitative research is defined by a certain perspective on the nature of human experience and is " . . . identified with a commitment to the logic of natural language as the preferred form for understanding human affairs" (Polkinghorne, 1989, p. 45). Thus, qualitative research uses natural language in its descriptions, such as interviews, as well as in its results.

The qualitative research method has only rarely been utilized to study psychotherapy process, generally, and the experience of resistance, specifically. It is unfortunate that this approach has been so under-utilized to investigate the phenomenon of resistance because it is, in many respects, an intuitive and appropriate match. The process of psychotherapy is an essentially human endeavor, one which involves people working and experiencing in relationship with each other. The study of this process thus involves the study of people and certain aspects of their experiences, namely psychotherapy and all of its components. Consequently, a qualitative approach to researching this area could yield insightful and meaningful results.

As research topics, psychotherapy process and resistance, are not separable from the clients and therapists involved in the process. Theory cannot, therefore, logically be separated from experience. In addition, a strict boundary cannot be drawn between the researcher and what is researched because the researcher is also a person who is inextricably involved in the process. In utilizing a phenomenological approach to qualitative research in this area, we make use of " . . . a method that remains with human experience as it is experienced, one which tries to sustain contact with experience as it is given" (Colaizzi, 1978, p. 53).

My presuppositions about resistance viewed it as a phenomenon which was much more than words, language, silence, or specific behaviors. It is something which is experienced, in terms of feelings and bodily sensations, by people, both clients and therapists, within the context of a relationship and a certain setting. As an experience, resistance is most accurately and effectively measured by a research approach whose focus is experience, not numbers, charts, or models. Thus, the phenomenological approach to research in the area of resistance may yield information on a different level from previous

studies, an experiential level. This approach is appropriate for this area of study and description because " . . . phenomenological methods are devised to investigate . . . the realm [of reality] that comes into being at the intersection of consciousness and the world--human experience . . . [these] methods have characteristics whose purpose it is to provide researchers clear access to this realm" (Polkinghorne, 1989, p. 58).

The phenomenological research method was chosen for this study because it focuses on the process of experience, thus permitting access to the "what" of the experience of resistance, rather than exclusively the "why" (Valle & King, 1978). This method also focuses the researcher on " . . . what is present or given in awareness", rather than on the independent reality said to exist "out there" (Polkinghorne, 1989, p. 41). The awareness of experience is what connects humans to their surrounding world, as well as to themselves. In phenomenology, there is no separation of mind from body, human from environment. Because resistance is a complex concept which is difficult to define accurately and meaningfully, it lends itself well to the flexible, more experientially-focused nature of the phenomenological approach.

Presuppositions

Whereas natural science attempts to eliminate bias in research through its rigorous methods and its distance from the phenomena, the phenomenological approach recognizes the inevitability of researcher bias and subjectivity at every stage of the research process. Phenomenological researchers do not, therefore, attempt to eliminate the bias but rather to bracket it, that is, " . . . to articulate predispositions and biases through a process of rigorous self-reflection" (Osborne, 1990, p. 81).

The presuppositions which I bring to this research range from the general, such as my beliefs about humankind, and the process of change, to the specific, such as my assumptions about therapists, clients, the therapy relationship, and the phenomenon of resistance. I have an optimistic view of humankind, in that I believe that people are generally good and that human nature strives towards personal growth, self-fulfillment, altruism, and life. I also believe that psychological change is an ongoing, lifelong process in which all human beings engage, in some form or another, whether it is accomplished through psychotherapy, self-exploration or process with other people.

One of my assumptions about psychotherapy and resistance, in particular, was that resistance occurs within the context of a therapy relationship, not as a function of one individual or another acting alone, but as the result of an interaction between two people. Thus, I conceived of resistance as an interpersonal process within psychotherapy, although I also recognized that it has intrapersonal components and that it occurs outside of psychotherapy, in other health-related disciplines as well as in the "real" world. My interest in conducting this research was focused more on the interpersonal level than on the intrapersonal level, and was specific to the process of change within a psychotherapeutic relationship.

I perceive the relationship between client and therapist to be of primary importance to the process and outcome of therapy. In beginning this research, I also assumed that therapists would attribute resistance more exclusively to clients, and that there would be a relationship between the therapist's belief system or theoretical orientation and how they conceptualized and attempted to resolve resistance. For instance, I expected a therapist practicing within a psychodynamic or psychoanalytic framework to place virtually all of the responsibility for resistance onto the client.

In addition, I believed that the therapist's own personal style, that is the way the therapist works with a client in the context of a theoretical framework and a given therapy setting, has a great bearing on therapy process and how resistance is dealt with. Having observed therapists working within the same framework and setting, and yet working very differently in their individual styles, I wondered how this affected their perspective and their treatment of resistance.

My interest in the topic of resistance has developed from several sources, both personal and professional. Professionally, as both a counsellor and a researcher, I am fascinated and puzzled by the phenomenon of resistance. I have experienced it as a counsellor in relationship with clients, in addition to observing it in other therapist-client relationships. Some of the thoughts and questions I had before commencing this research project are elucidated by my pre-interview bracketing notes: "my interest comes from a great deal of exposure to observing therapy 'in action' and being intrigued by how it sometimes really works and flows and moves; and how, at other times, it can be so slow

and stuck and seemingly unproductive. What makes these differences? How do both clients and therapists influence this process? Or is it only one of them that does? Or does one of them influence or control it more than the other?"

As a new and relatively inexperienced therapist, I am also very interested in learning about the client's perspective of resistance. I have heard and read a lot about what other therapists think and how they theorize about it, but I do not know much about what the client's thoughts, feelings, and reactions to resistance are. I am hopeful that the experiences which the clients will share with me will yield some enlightening and useful information for me, as well as for other therapists. I hope to use the experiences gathered from this research to enrich my own personal and professional life.

Personally, I am interested in the concept of resistance because, having been a client and having sat in the other chair, I am aware of both the constructive and destructive aspects of resistance. Resistance can be constructive when a therapist recognizes and validates it as a necessary function for the client; the client is thereby given permission to experience the resistance. Resistance can also, however, be a destructive force when it becomes a power struggle between client and therapist or when it serves as an expression of anger and resentment within the therapeutic relationship.

I believe that this study will provide a unique perspective on the complex experience of resistance, which is such an integral part of psychotherapy. I think that if we, as counsellors and researchers, can understand resistance more completely and clearly, we can become more effective in working with our clients to accept it, move through it and resolve it.

Participants

Participant selection was aimed at eliciting people with a variety of backgrounds and diverse therapy experiences in order to obtain a thorough and comprehensive description of the phenomenon of resistance.

The first step in participant selection was to approach therapists who would be interested in participating in the research. The goal in therapist selection was to have a representative sample of therapists in terms of theoretical orientation, experience, work

environment, and gender. Therapists were solicited through the experimenter's personal contacts and through recommendations by other therapists.

Two of the therapists were professional acquaintances of the experimenter, and the other two were contacted as a result of recommendations made by other therapists. Therapists were two men and two women, all of whom have doctorate degrees and three of whom are chartered psychologists. Settings in which the therapists practice include private practice (two therapists), a hospital setting (one therapist), and a community/agency setting (one therapist). Therapists had been practicing from four to over fifteen years, and their theoretical orientations included all of the following: cognitive-behavioral, psychoanalytic, experiential, and behavioral/rational-emotive.

The next step in participant selection was to solicit clients from these therapists' caseloads. Since the aim of this study was to compare therapists' and clients' experiences of resistance, therapist-client pairs were selected, instead of therapists and clients who were not working together, so as to have the context of a relationship as a foundation on which the clients' and therapists' experiences could be compared and contrasted. Client selection was left to the therapists' discretion, with the caveat that the therapy contact should be a minimum of one year. I hoped that the clients selected would have diverse backgrounds and experiences as a result of the nature of the therapy settings and the various theoretical orientations of the therapists. I also encouraged the therapists to select the client sample across gender.

It is important to note that this method of client selection is inherently biased because the therapists made the decision about whom to select from their caseloads. Even though most of the therapists said that they selected their most resistant clients, all of these relationships must have been characterized by a strong therapeutic alliance because longer-term therapy would otherwise not have been possible.

Clients were three women and one man, who were in their 30's and 40's. Three of the clients were married, one was single. Two of the clients had children. Reasons for initiating therapy included burnout due to work stress, pain management, lack of decisiveness and assertiveness about life decisions and goals, and depression and suicidal thoughts.

All four of the clients had been in therapy with these particular therapists for a minimum of one year. This stipulation regarding the length of the therapy contract was made to ensure that a solid therapeutic relationship had developed between client and therapist. However, this stipulation would affect the results of the study because, in essence, these therapy relationships are classified as long-term by the nature of the one-year minimum requirement. Long-term psychotherapy is usually characterized by a more in-depth therapeutic relationship, different types of issues (versus short-term therapy), and, possibly, a different type of resistance.

Procedure

Initially, therapists were contacted and asked to participate in the study. The nature and purpose of the study was explained to them verbally, either over the phone or in person. The therapists were then asked to select a client from their caseload who met the minimum criterion and who they thought would be an appropriate and willing participant. The therapists approached these clients and presented a basic outline of the study and its requirements. (See Appendix A). Therapists ensured that clients were given a choice as to whether to participate and that they willingly consented to participate. Once consent was obtained, the therapists gave the clients' names and phone numbers to the experimenter, who contacted the clients and explained the nature, purpose, and required involvement of the study.

Interviews were scheduled in conjunction with both the therapists and clients, giving the client's schedule first priority. At the start of each interview, the purpose of the study and the amount of involvement was explained again in both verbal and written formats (see Appendices A & B). Confidentiality and the option to discontinue the study at any time were emphasized, and consent was obtained from all participants (See Appendix C). All four clients were interviewed immediately after a therapy session; three of the four therapists were interviewed immediately after the clients; and one therapist was interviewed three days after the session due to scheduling difficulties.

The interview format was open-ended and focused on eliciting the participants' experiences of resistance in a therapy session. The experimenter utilized a standard set of questions in order to obtain the same general information from all participants, and to aid

in prompting when needed during the interviews (See Appendix D). These questions were formulated in an attempt to allow participants to explore their experience of resistance in whichever form they chose, whether this form was interpersonal, intrapsychic or both.

The experimenter began each interview by establishing rapport and attempting to join with the participant's process. In the client interviews, the experimenter usually began by eliciting information about the client's background and about what had brought the client to therapy. The experimenter utilized techniques such as active listening, reflection of content and feeling, and the use of prompts and probes to elaborate certain material throughout the interviews. The interviews were approximately one hour in length and were audiotaped, and later transcribed.

Data Analysis

The eight interviews were transcribed, read, and re-read by the experimenter in order to gain familiarity and a thorough understanding of the participants' descriptions of their experiences. The initial step in the data analysis was to highlight sections of text within the transcripts which seemed to address the research question, namely the participants' experience of resistance in the therapy session. These sections of text, or meaning units, were subsequently paraphrased, in such a way as to remain close to the participants' actual language and intended meaning. The next step involved allowing themes, which were more removed from the original statements, to emerge from the paraphrases (See Appendix E for an example of this process).

After this process was completed for each of the eight transcripts, the resulting themes were analyzed, in terms of the original participant statements and the paraphrases, to determine their pertinence to the topic of resistance, and any themes which were not related to the topic were eliminated. The themes were then pooled together for all four clients and for all four therapists, into two separate groupings, and these were then clustered into groups of themes or "thematic clusters." These thematic clusters were named, completing the first order analysis. The final step was to then group and name these clusters, which completed the second order analysis.

The first order thematic clusters emerge when related themes from the transcripts are combined so as to present a detailed description of an aspect of the experience of

resistance. The second order thematic clusters are another level of analysis and understanding of the participants' experiences. They represent a further abstraction of the first order themes, resulting in a concise, encompassing representation of the experience of resistance.

Upon completion of the data analysis, the first order thematic clusters were summarized and described in a concise format for each of the two groups, therapists and clients. These summaries were then sent to the participants who were asked to complete a questionnaire and feedback form about the relevance and appropriateness of these themes to their experiences of resistance. All four therapists, and two of the four clients, completed and returned their questionnaires.

The therapist feedback indicated general agreement with most of the first order thematic descriptions; that is, these descriptions seemed to match the therapists' experiences of resistance in psychotherapy. The disagreement with the "fit" of certain themes to the therapists' experiences seemed related to their various theoretical orientations. For instance, there was some disagreement with themes describing the congruency of therapist and client therapeutic agendas. Some of the therapists felt that these themes did not match their experiences because they were working within theoretical frameworks, such as psychoanalytic or cognitive-behavioral, which espoused different explanations for resistance in terms of the therapeutic agenda.

One therapist highlighted the fact that his experience of client resistance was directly related to the stage of psychotherapy. He noted that the early stages of psychotherapy present different patterns of resistance than the middle and later stages. These different patterns manifested themselves, with respect to the client interviewed for this research, in resistance to the presenting issue at the beginning of psychotherapy, and to increasingly deep-seated, more difficult issues in the more advanced stages.

Another therapist described psychotherapy as a collaborative, mutual experience in which the therapist is influenced by the client and vice versa. She experienced resistance in psychotherapy when the client and therapist become polarized so that the therapist becomes the healer and the client becomes pathological.

The client feedback also indicated agreement with virtually all of the first order thematic descriptions. The two clients who responded were particularly positive about the themes related to the experience of resistance as a push-pull process in psychotherapy. Both clients felt that this resistance was due to some internal blockage on their parts, not attributable to the therapist or the therapy setting. In addition, these two clients felt that the theme reflecting the ability to move past the resistance was not congruent with their experiences because neither one of them was certain of how to do this.

Reliability and Validity

Two aspects of the phenomenological method are used to assess the reliability of its research: intersubjective agreement and reflected subjectivity (Osborne, 1990). Intersubjective agreement refers to the idea that human perception occurs within certain perspectives and contexts. Thus, interpretation of results within a phenomenological framework can produce findings which are both contradictory and coherent (Osborne, 1990). Whereas reliability in the traditional sense, within a natural science framework, may be reduced by the unique sensitivity of various interviewers interpreting a given set of interview data, reliability within the phenomenological arena is said to be enhanced by these different sensitivities because they result in " . . . a more nuanced and wider picture of the themes of research" (Kvale, 1983).

Reflected subjectivity ensures reliability because the variable facts obtained through phenomenological research are transcended by its focus upon meaning (Osborne, 1990). A stable meaning should result from the participants' various experiences of the phenomenon studied because the interviewer's accurate interpretation of the participants' individual descriptions leads to a more global understanding of the phenomenon.

Validity within phenomenological research is assessed in four ways: bracketing, goodness of fit, convincing arguments, and external validation (Osborne, 1990). First, in bracketing, the researcher describes his/her presuppositions about, and orientation to, the phenomenon to be studied and delineates the procedure and data analysis so that the reader can understand the researcher's interpretations of the data (Osborne, 1990). This aspect of validity was fulfilled in the present study by the description of the researcher's presuppositions in the methods chapter.

Second, goodness of fit refers to the idea of checking the researcher's interpretations with the participants to determine the amount of congruence between the interpretations and the participants' experiences of the phenomenon. The researcher in this study did attempt to validate the results with all participants who were willing to do so.

Third, the process of presenting convincing arguments is one of the most crucial aspects of validating the interpretations of phenomenological research (Osborne, 1990). The researcher attempts to convince the reader as well as the research community of the accuracy and validity of the research findings. Polkinghorne (1989) states that "the degree of validity of the findings of a phenomenological research project . . . depends on the power of its presentation to convince the reader that its findings are accurate" (p. 57). In order to achieve this validity, the reader should be able to follow the researcher's thought processes which led to the conclusions drawn and accept them as valid (Kvale, 1983; Polkinghorne, 1989). This aspect of validity was fulfilled in the present study by the researcher's attempt to carefully delineate and explain the procedure and data analysis, by making convincing arguments for the results, and by submitting both the data analysis and the final descriptions to fellow students and professors to read and provide feedback.

Fourth, external validation refers to the extent to which the description of the phenomenon is congruent with other people, outside of the study, who have experienced the phenomenon (Osborne, 1990; Polkinghorne, 1989). Thus, in the context of the present study, the description of resistance within psychotherapy should resonate with other clients' and therapists' experiences of this phenomenon. This aspect of validity was assessed only with respect to two therapists who read the final paper. Further validation would include having clients and more therapists read the description of the phenomenon of resistance in this study to assess the amount of resonance between their own experiences and this description.

Chapter 4: Results

Ten first-order and three second-order thematic clusters were developed from the data analysis for each of the two groups of participants, therapists and clients. These results are presented below, with the second-order thematic descriptions for each group, therapists and clients, presented first, followed by the first-order thematic descriptions comprising each second-order theme.

Therapists' Second Order Thematic Descriptions

These second order themes represent an overall synthesis of the therapists' experiences of resistance in a psychotherapy session with their clients. There are three second order themes: incongruence, client communication, and resolution (Table 1, p.38).

(1) Incongruence: Therapeutic process directed by therapist's agenda.

This theme encompasses three first order thematic clusters, which focus on the therapist's agenda for the therapy session. These clusters reflect experiences common to all four therapists in this study. The initiative and direction for the therapeutic process was determined by the therapist's interpretation of the client's issues, and their translation into a therapeutic agenda. The client was perceived as resistant when he/she did not comply with the therapist's interpretation and translation of these issues. The therapist and client agendas were incongruent, and therapy consequently came to a standstill.

The therapist was viewed as essential to the working through of the client's resistance. The therapist utilized both directive interventions and a compassionate attitude to work together with the client to resolve the resistance. The therapist also recognized the necessity of the client resistance to the continuation of the client's process, as well as to the progress of therapy. Resistance was characterized as a non-linear process: it moves continually back and forth, not in a straight line. An appropriate analogy is that therapist and client are like dance partners, engaging in the dance which is therapy. They move together in unison, stepping forward and backward, adjusting to each other's sense of rhythm and the actual steps of the dance.

Table 1: Second Order Thematic Description of Therapists' Experience of Resistance

Second Order Thematic Cluster	First Order Thematic Cluster
1. Incongruence: Therapeutic process directed by therapist's agenda.	(1) Incongruent agendas: client non-compliance with therapist's agenda.
	(2) Therapist intervention necessary for resolution of stalled therapy.
	(3) Attribution of therapist blockage and frustration to client process and agenda.
2. Client communication of own therapeutic process and agenda.	(1) Self-other congruence: client's struggle to address own and therapist's agendas; inevitability of blockage in therapy.
	(2) Maintenance of client integrity and control over change process and therapeutic agenda.
	(3) Therapy as a mirror of life: the reciprocal nature of the client's process inside and outside the session.
3. Resolution: Therapist-client congruence in therapeutic process.	(1) Congruent agendas: acceptance of client agenda as the therapeutic agenda.
	(2) Use of therapist blockage to increase congruence with client process.
	(3) Importance of positive therapeutic relationship and therapist-client congruence.
	(4) Adaptation of therapist style and techniques for optimum congruence with client process.

This dance can sometimes result in resistance and frustration on the therapist's part, as well as the client's. The therapist attributed most of his/her resistance to the client's process, either the client's resistance or the client's persistence with his/her own agenda. There was also a sense of therapist frustration when therapy became stalled or blocked, and when the client's work did not continue and progress within and between sessions. The therapist attempted to maintain clear boundaries between his/her own process and the client's and to discover a way to balance both partners' agendas for the client's optimal benefit. Therapist resistance was also viewed as an opportunity, not only as a liability, because it provided the seeds for learning and self-awareness.

Therapists' First Order Themes for Second Order Theme: Incongruence

(1) Incongruent agendas: Client non-compliance with therapist's agenda.

A focus on the therapist's agenda during the session resulted in the perception of the client as resistant or non-compliant with the therapist's interventions or with the general direction of therapy. A focus on the client's agenda was seen as avoidance of the therapist's agenda. The therapist interpreted and reformulated the client's issues, and is seen as the "expert" on the client's needs and goals. This theme is illustrated by the following therapist description:

> . . . so we always come back to these issues of what she can do . . . I try to get her to think about the way she reacts to things at home and the dynamics that are going on at home . . . and she will give me information about it, but if she senses that. . .I'm coming around her taking responsibility . . . she blocks.

(5) Therapist intervention necessary for resolution of stalled therapy.

Therapists took responsibility for addressing the client's resistance, simultaneously recognizing the resistance as vital to the continuation of the client's process and therapy progress. In one therapist's words, " . . . I take responsibility for not permitting the session to . . . become this quagmire of resistance, 'cause I just don't think that's . . . ethical . . . therapeutic, I just don't think it's helpful."

Therapists utilized directive interventions, such as focusing on specific issues, highlighting contradictions, shifting the pace of the session, recommending other options, and evaluating progress, to confront the resistance. One therapist noted that:

> . . . I often experience her--I think she would use the word 'stuck' . . . I've wondered at times what my part in that is, keeping her stuck rather than helping her get un-stuck, and so I've suggested . . . a consultation with the larger team . . . alternate modalities, like group therapy . . . second opinions in terms of therapists.

Indirect interventions, such as a therapist attitude of acceptance and compassion, and a collaborative alliance with the client, were also employed to resolve the resistance. One therapist described his reaction to the client's resistance as " . . . sympathy, compassion or concern. . .because I see her struggling with trying hard, wanting to make some changes in her life." Resistance resolution was characterized by the therapists as a forward and backward process, a " . . . push-pull . . . one step ahead, two back."

(3) Attribution of therapist blockage and frustration to client process and agenda.

Therapists expressed their frustration with the client's resistance, pursuit of own agenda, negative perception of the therapist during blockage, discontinuity of work between sessions, and with therapy which was stalled. This frustration was expressed by one therapist as " . . . the counter-transference . . . at least in my feeling stuck is, like not this . . . again . . . here we go again . . . this is interminable, there doesn't seem to be any kind of learning from the experience."

Therapists attributed their resistance to collusion with the client's confused, unfocused process. They did, however, recognize both the useful and frustrating aspects of this resistance; namely, the opportunity to learn from it, as one therapist stated, " . . . it's learning from my own resistances," yet its interference with the therapist's intuition: "so resistances can feed that, in the sense of blocking my own intuitions."

Therapists' Second Order Thematic Descriptions (continued)

(2) Client communication of own therapeutic process and agenda.

This theme was developed from three first order thematic clusters which reflect the client's process in the therapy session. These clusters reflect experiences common to all four therapists and were formed from the therapist's interpretation of the client's experience of resistance and of the therapeutic process. From this perspective, resistance was seen as resulting from the client's struggle to simultaneously fulfill both his/her own agenda, in terms of the issues brought to therapy, and the therapist's agenda, in terms of how the therapist interpreted the client's issues. The client's struggles and frustrations in confronting and resolving difficult issues led to points in the session which became stuck or blocked. This resistance happened despite the client's motivation for therapy and despite a positive relationship between client and therapist. In essence, the client was perceived as struggling to be both self-congruent and other-congruent.

Resistance is a complex, multi-dimensional force in psychotherapy. The therapist realized that resistance has a positive and necessary purpose within the context of therapy and the client's process. This purpose is to enable the client to maintain a sense of control over his/her process, that is, to determine the nature of the therapeutic agenda, the pace of the session, and the form and rate of therapeutic change. The client was seen as being able to regulate the process of therapy through the use of resistance.

The client's process inside the therapy session was viewed as inextricably linked to that outside the session. Consequently, events inside the therapy session impacted the client's real life and vice versa. The client's process in session reflected his/her real life difficulties. The therapy session was a place to practice new skills and coping mechanisms, and the therapist was both mirror and sounding board.

Therapists' First Order Themes for Second Order Theme: Client Communication

(1) Self-other congruence: Client's struggle to address own and therapist's agendas; inevitability of blockage in therapy.

This theme reflects the therapists' experience of resistance in a therapy session in terms of both its causes and expression. Resistance was viewed as resulting from client personality traits, the therapy relationship, and factors inside and outside the therapy

session. One therapist described this aspect of resistance in the following way, " . . . I think in the beginning I would see it as sort of classic resistance . . . but I think it's more than that . . . he . . . has profound difficulties interacting with anyone."

Therapists perceived client resistance in various forms, such as the client's self-criticism, frustration, fear of failure, and the struggle between helping self and enlisting the therapist for help: "I think she gets very frustrated . . . irritated, I think she experiences some ambivalence towards me, like, rescue me versus . . . I know I gotta do this on my own . . . ."

Resistance was also experienced as the therapists' sense of client reluctance, unwillingness and ambiguity in terms of beginning therapy sessions and accepting therapist interventions and suggestions. One therapist described this reluctance in the following manner:

> . . . my . . . suggestions, or my . . . thoughts about why it might be useful . . . was met with a, yah, you might be right, but . . . so she's . . . thinking of all of the arguments against it . . . I know that she would use that as an excuse.

Therapists reported that resistance was a resilient force in therapy because it persisted despite client motivation, a positive therapeutic relationship, and sufficient material for discussion in session.

(2) Maintenance of client integrity and control over change process and therapeutic agenda.

Therapists recognized the positive and useful aspects of resistance, in terms of the client's struggle to confront issues and activate change during therapy. In one therapist's words:

> . . . it's more a sense of . . . using it as . . . this is what he needs to do to feel safe, and . . . if he has to stand on the . . . diving board for two hours before he dives in, that's what he has to do . . . .

Resistance was identified as serving a dual function: to express the client's push-pull struggle between change and remaining the same, and to maintain the client's integrity and control over the direction and pace of therapy. One therapist described it as

the client's " . . . way of . . . maintaining some control, and identifying with something that she can accept as being okay." Therapists expressed respect for both sides of the client's struggle and perceived their role as discovering a "middle ground" for the struggle:

> . . . the way I frame the whole thing about being blocked or being resistant is, not that there's something bad about her, or that there's something even necessarily bad about our relationship, but it is that she experiences competing forces for information to come out into the open versus information staying . . . and I want to respect all those sides and I try to convey that attitude to her.

(3) Therapy as a mirror of life: the reciprocal nature of the client's process inside and outside the session.

Therapists identified the client's process within the therapy session as both a reflection of the client's difficulties outside of the session, and as a rehearsal for new learning to deal with those difficulties more effectively. The therapy session thus became a microcosm of the client's real life world, which magnified the client's problems in order to examine them carefully and to begin the process of change. One therapist stated that " . . . then it moves onto more of just the same stuff, me modeling almost for him, and to . . . engage with someone . . . I just don't think he knows how to engage with anyone." The therapist was viewed as both "a mirror person" and a role model.

A major goal of therapy is to bridge the transition between the utilization of new skills learned in session into the client's world outside of session:

> . . . it's like stirring a pot of cold porridge . . . in the week, or the two weeks . . . between the sessions . . . by the end of the session, it's this bubbling and liquid and flowing and it's hot stuff, and then, it sort of cools off for two weeks, and comes back, and it's sort of this plodding, thick . . . very sensation of trying to get him cooking again.

Therapists' Second Order Thematic Descriptions (continued)

(3) Resolution: Therapist-client congruence in therapeutic process.

This theme is composed of four first order thematic clusters which reflect the significance of therapist-client congruence in terms of the therapeutic process. Three of the four clusters represent experiences common to all four therapists, whereas one cluster represents experiences of only half of the therapists. It is the culmination of joining both client and therapist together in a positive and effective therapy relationship. Therapist-client congruence occurs when two individuals move as one in the dance of therapy. This congruence may be likened to the ideal combination of Fred Astaire and Ginger Rogers in the world of dance. At the core of this theme, however, is not necessarily a perfect match of therapist with client, but, rather, an awareness that therapy can only truly succeed when both people work together in the client's best interest.

The therapist recognized an inverse correlation between acceptance of the client's agenda for the direction of therapy and the amount of resistance experienced in a given therapy session: as therapist acceptance of the client's agenda increased, resistance decreased.

The therapist utilized his/her own resistance in a productive manner to aid the client's process. Therapist resistance was also a signal for the therapist to better match the therapeutic approach and interventions to the client's needs and goals. Thus the therapist used his/her resistance to become more congruent with the client.

Other factors deemed important for optimum therapist-client congruence were a positive therapy relationship and a flexibility and openness in the therapist's style and techniques. Whereas these factors are more general to therapy, rather than specific to resistance, they appear to be necessary and important, to the overall therapeutic process, which includes resistance. They provide a foundation from which therapist and client work together to confront and resolve the client's issues. The concept of resistance per se cannot be removed from its context within therapy and the therapy relationship.

Therapists' First Order Themes for Second Order Theme: Resolution

(1) Congruent agendas: Acceptance of client agenda as the therapeutic agenda.

This theme reflects the therapist's realization that discounting the client's agenda resulted in increased resistance, and, conversely, that acceptance of the client's agenda as a guide for the direction of therapy decreased resistance, increased future acceptance of the therapist's agenda, and allowed therapy work to commence. One therapist described the resolution of resistance, through congruence with the client, in the following way: " . . . for several months, I've felt that something at the core of her was in need of healing, and that she needed to share that . . . and once that inner history of hers came out . . . a main resistance has dissipated . . . ." Another therapist described her congruence with the client:

> . . . usually I let her talk . . . between periods of time that I try to make some intervention, or try to promote a different perspective. I allow her to tell me her story. And that seems to be important because you can visually see . . . her get upset and uptight, and yet when you allow her then . . . to tell her story, and I take the supportive role, she gets relaxed and then we can try again.

(2) Use of therapist blockage to increase congruence with client process.

Two of the four therapists addressed their resistance in order to minimize its interference with the client's process and progress in therapy. These therapists translated their resistance into interventions about the client's resistance, feelings and current process. They confronted their resistance in session through suggestion of alternative therapy options which were more congruent with the client's needs, through adjustment of the pace of the session, or through exploration of the reasons behind the resistance. One therapist explored her resistance in the following manner: " . . . what I do is I tolerate those feelings, and I try and translate them into something that . . . is an intervention in terms of what is this telling me about him . . . the translation of my own counter-transference."

(3) Importance of positive therapeutic relationship and therapist-client congruence.

Therapist variables, such as balance, congruence and respect, were identified as significant for the client's therapy work and eventual favorable outcome. The therapist consistently monitored and evaluated the course and progress of therapy, and weighed the various therapy alternatives in favor of the client's maximum benefit: " . . . because I move back and forth from supportive . . . therapy to . . . trying to intervene in some way, she does view me as a person . . . as being a good listener and supporting her".

The alternatives which the therapist chose to utilize in session were optimally matched to fit the client's particular needs, style and process. As one therapist aptly stated:

> . . . there's other people where it feels like you're working away with fine sandpaper, and just sort of do a little sanding every day . . . and then eventually . . . some spots get thinner and something starts to come out . . . and you keep on sanding . . . I think there's all kinds of people.

. Therapist-client congruence was seen as an important therapy variable. A positive working alliance was established on the basis of therapist respect for the individual client.

(4) Adaptation of therapist style and techniques for optimum congruence with client process.

This theme reflects the therapists' ability to remain flexible and open to diverse treatment options and interventions, inside and outside of therapy. One therapist illustrated the flexibility of his approach in the following way:

> . . . she paced all over the room, so I got up and paced all over the room, too (laughs) . . . I don't know that it helped in the session, but I think it--if you think of it as sort of long-term chipping away, I think it did help the relationship . . . .

Therapists gauged their approach and focus in session to encourage a broader client awareness in terms of therapy and their overall well-being. The client's process was enriched by the therapist's use of self in session:

> I like to keep options open and I experiment within a context of respect for her, again. And then I try to also stay tuned into my own awareness, how am I feeling,

what might whatever she is doing be evoking for me, and then how can I use whatever is being evoked for me in a therapeutic sense . . . .

Clients' Second Order Thematic Descriptions

These second-order thematic clusters represent an overall synthesis of the clients' experiences of resistance in a psychotherapy session with their therapists. There are three second order themes: self-regulation, therapist congruence, and therapy as a safe sanctuary (Table 2, p. 48). A common thread which is woven throughout this representation of the experience of resistance is the client's focus on process. Though clients are concerned with progress, improvement and change, the general consensus indicated that the process of therapy is of primary importance.

Another interesting aspect of these thematic descriptions is their emphasis on the context of therapy as a whole, more so than on the specifics of resistance. In comparison to the therapists, the clients more often related their experiences of resistance as intertwined with, and based on a foundation of, a positive therapeutic relationship and a safe therapy environment.

(1) Self-regulation: Client control of therapeutic process and change.

This theme is composed of four first-order thematic clusters which reflect the client's process during therapy; specifically, the client's experience of blockage and the development of a sense of autonomy and competence. These clusters represent the experiences of most of the clients in this study.

The client's experience of blockage was a paradoxical one: blockage was seen as both a positive and a negative component of the therapy process. On the one hand, blockage was viewed as positive in the sense that it was necessary to therapy, it served a purpose; namely, blockage expressed the client's justifiable ambivalence. This ambivalence reflected the client's inner struggle between the push to change, which is the motivating force behind the initiation of therapy, and the pull to stay the same, which is an intrinsic aspect of human nature. Another positive aspect of blockage was its function as a self-protective mechanism. Blockage served as the client's safety valve, when therapy was moving too quickly or in the wrong direction (i.e., when the therapist's agenda became primary), it allowed the client to temporarily halt the therapeutic process.

Table 2: Second Order Thematic Description of Clients' Experience of Resistance

Second Order Thematic Cluster	First Order Thematic Cluster
1. Self-regulation: Client control of therapeutic process and change.	(1) Manifestation of client's inner struggle, between change and status quo; blockage as a self-protective mechanism.
	(2) Therapy at a standstill: client blockage as a negative force.
	(3) Self-empowerment through blockage resolution and therapeutic progress.
	(4) Self-awareness: progress through recognition of issues and process.
2. Therapist congruence with client's therapeutic process.	(1) Therapist approach and strategies congruent with client process.
	(2) Honoring the client's process: the congruence of therapist approach to client needs.
	(3) Dual nature of therapist's role: professional expertise and personal compassion.
3. Therapy as a safe sanctuary.	(1) Client perceptions of therapist instrumental to therapeutic process.
	(2) Importance of a positive therapeutic atmosphere to client change and progress.
	(3) Trust and safety: the cornerstones of congruence in therapy.

On the other hand, blockage was also viewed as a negative force in therapy because it can result in a sense of the session as being unproductive, or "off track", and in the client feeling personally frustrated and hopeless. Most of the clients experienced blocked sessions as unproductive when the blockage was excessive or long-standing. The consequent feelings of frustration and hopelessness were often related to the perception of being "stuck", immobile, and not progressing. It is interesting to note that clients always accepted full responsibility for the blockage and did not, in any way, attribute it to their therapists.

The other component of this theme is the client's development of a sense of mastery over his/her issues, process, and improvement. The clients reported a feeling of empowerment at becoming increasingly self-aware and able to recognize their process. They also discovered the ability to identify and overcome their blockages in session when they occurred, and consequently experienced satisfaction with their progress. As a result of the work in the therapy session, the clients realized benefits outside of the session.

Clients' First Order Themes for Second Order Theme: Self-Regulation

(1) Manifestation of client's inner struggle, between change and stasis; blockage as a self-protective mechanism.

Clients described blockage in session as an expression of their inner push-pull struggle between change and staying the same, confronting difficult issues and avoiding them. One client reflected on the difficult issues which lead to blockage, " . . . I get stuck not knowing whether I should stay with her . . . or go, because there's too many conflicting things . . . that's the thing that . . . sticks . . . ."

Blockage served a necessary and useful function in terms of self-protection, to safeguard and maintain the client's integrity and control over the nature and extent of the therapeutic work: " . . . then I think I got a little scared and just kind of got confused then . . . not really sure how to deal with . . . what the point we'd gotten to . . . it's almost like an instinctive protection, I gotta take a step back again." At the same time, clients often perceived blocked sessions as unproductive. One client described this negative aspect of blockage in the following way, " . . . I really don't even remember most of the session just because it's--in my gut, I know that it somehow didn't click for me that day . . . ."

(2) Therapy at a standstill: Client blockage as a negative force.

Clients experienced feelings of frustration and hopelessness when blocked in session, a "hopeless, despairing thing." Blockage was a negative experience because of the sense of both immobility and lack of progress which it created within the client's therapeutic process. The client accepted the majority of the responsibility for blockage. One client described her experience in this way, "frustrating. Frustrating as hell . . . usually when I'm blocked, I'm numb . . . like nothing, feel nothing . . . so then I just get frustrated and mad at myself 'cause I can't seem to get anywhere."

(3) Self-empowerment through blockage resolution and therapeutic progress.

The client discovered the ability to confront and overcome blockage in therapy. The client took the initiative to move past the blockage and to continue the therapy work towards progress and change. This initiative is reflected in one client's statement that, "it's like in my gut, all of a sudden, no . . . that's not right and then all of a sudden I have to explain it, no this is the way, so that seems to help when I'm really stuck." The client's increased feelings of competence led to a greater ability to return to the therapeutic "track" following an "off track" direction during blockage. One client explained his newfound competence as, "no, I don't stay stuck . . . I can get back on some kind of track . . . well, I might have to go back to anything to get back to something."

(4) Self-awareness: progress through recognition of issues and process.

The client became increasingly aware of his/her process in the therapy session, for instance, in identifying issues which needed to be addressed and resolved. The client attained new skills and coping mechanisms, or clarified and strengthened "old", dormant skills. Consequently, the client developed a sense of competence and self-confidence in his/her ability to take initiative and to resolve difficulties. The client's positive outlook permeated into life outside of the therapy session. One client described his increasing self-awareness and feeling of competence as:

> . . . it's also getting easier . . . it's kind of like a funnel thing . . . it's a little easier because there was . . . so much, now there doesn't seem to be as much that--I guess that's part of being stuck, too, a little bit, I think I sort of covered those and

. . . there's really nowhere else to go . . . there's only one way to go . . . one thing left to work on.

Clients' Second Order Thematic Descriptions (continued)

(2) Therapist congruence with client's therapeutic process.

This particular theme, which consists of three first-order thematic clusters, expresses a significant aspect of the client's experience of resistance and the therapy process. These clusters reflect experiences common to all of the clients. The clients recognized, and consistently referred to, their process as occurring within the context of a relationship with another individual, the therapist. A therapist approach which was congruent with, or matched, the client's process was identified as necessary for therapy, resolving blockages, therapeutic change, and progress. Therapist congruence led to positive therapy, whereas therapist incongruence led to blockage, conflict and possible termination of therapy. When the therapist was incongruent with the client's needs and therapeutic process, the client felt discounted and minimized.

The client viewed the therapist as utilizing a combination of flexibility, creativity, and an understanding of the client's issues and personality in order to intervene effectively when needed. In addition, a supportive and trustworthy therapist allowed the client to feel safe to reveal and explore his/her inner most depths.

Most of the clients spoke of their therapists in an exclusively positive frame of reference. In discussing both the therapy process in general, and resistance in particular, the clients unanimously praised their therapists and were grateful to them. Clients also generally accepted responsibility for any aspects of therapy which were not positive, such as blockages in session. Therapists were characterized as caring, compassionate, expert, and professional. Clients varied somewhat in how they perceived the therapist as a person: one client viewed her therapist as someone who exceeded the expectations of the professional role in terms of her compassion for her clients; another client maintained the therapist at a safe distance, as only a professional, not a person, in order for her to be open with the therapist.

Clients' First Order Themes for Second Order Theme: Therapist Congruence

(1) Therapist approach and strategies congruent with client process.

The client identified a flexible and creative therapist approach as significant to resolving the blockage in session. The client perceived the therapist as utilizing his/her knowledge of the client's personality and particular therapeutic process to develop and implement specific techniques to help un-block a "stuck" session. One client described this process as " . . . it depends on the situation . . . he'll give me an example of something and then, that (snaps fingers) just gets me going". Another client reported that " . . . he's starting to learn my personality a little bit too so he knows . . . kind of what buttons to push".

Therapist qualities, such as compassion and trustworthiness, were seen by the client as important to the success of interventions aimed at resolving the client's blockage. One client described her interaction with her therapist in the following manner " . . . with R., there was some blockage . . . but I trust him implicitly".

(2) Honoring the client's process: the congruence of therapist approach to client needs.

Therapist congruence, in terms of techniques and style of intervention, with client issues and style of understanding resulted in enhanced client openness and self-awareness, willingness to work, positive perception of the therapist and therapy, and better outcome. Therapist congruence with the client's process was exemplified by the following client statement, " . . . it's more--fits better . . . it's not like you're being told a process because that's the process that you should hear, it's the process that is. You're hearing what is really going on."

In contrast, therapist incongruence with the client's process resulted in blockage, conflict about the direction of therapy, client feelings of being discounted, and, sometimes, termination of the therapy contract:

> I got the idea that he thought I was on the wrong track or something, and I, for once, really felt that I was on the right track, and . . . I was very angry and I just didn't go back. I realized that . . . we weren't going anywhere.

(3) Dual nature of therapist's role: professional expertise and personal compassion.

The therapist's role, in relation to the client's process in therapy, was viewed from several different client perspectives. From one perspective, the therapist was perceived as both a caring, compassionate person by nature and an expert who went beyond the scope of the professional role to help the client. This positive perception of the therapist is reflected in one client's description:

> compassion . . . she's very dedication [sic] to her patients, she was to me, she's easy to talk to, she's just a fantastic person--like I said, after . . . a session that I had she didn't have to walk me across to the _____, but she did . . . she took . . . what I was saying to her own, and she knows me better than I know myself.

From another perspective, the therapist was perceived in a strictly professional manner so that the client could maintain a safe distance when discussing very personal issues. This view was described by one client, " . . . I kind of have to separate him in like, he's not really a person, in one sense, he's just there, and he's the expert, and I can talk and he can . . . help me . . . ." The client appreciated the importance of the therapist's professional attitude to the therapeutic work and progress.

Clients' Second Order Thematic Descriptions (continued)

(3) Therapy as a safe sanctuary.

This theme resulted from the combination of three first-order thematic clusters, which relate to the clients' views of the therapy setting. These clusters reflect experiences common to all of the clients. As previously noted, clients emphasized the foundations of therapy, such as the overall atmosphere of the therapy setting and the nature of the therapy relationship, as essential to their experience of resistance. Thus, clients discussed such issues as positive therapist characteristics, a positive therapy setting, and the necessity of trust and safety in both the therapist and the therapy.

All of the clients interviewed seemed to have a positive working alliance with their therapists, as they described them as being supportive, gentle, caring, and present. Therapists were also viewed as respecting the client's process and as being partners or allies with the client in the struggle to confront and resolve important issues. Clients felt

validated and safe with their therapists, which consequently led them to take risks and deal with painful issues.

The clients' perceptions of their therapy settings were largely related to their relationships with the therapists. A positive working alliance with the therapist usually indicated a positive view of the therapy setting, as a safe and supportive place for the client to unfold his/her process. Thus, again, therapist respect for the client as both a person and someone seeking help, validation of the client's struggles and difficulties, and congruence with the client's process during therapy were identified as necessary for the client to feel safe with the therapist and the therapy setting. This safety, in turn, allowed the client to begin the work of therapy.

Clients' First Order Themes for Second Order Theme: Therapy as a Safe Sanctuary

(1) Client perceptions of therapist instrumental to therapeutic process.

The therapist's approach, both generally, in terms of the creation of a safe, supportive therapy environment, and specifically, in terms of direct and indirect interventions, was intrinsic to the client's working through of issues during the therapy process. One client described her therapist's approach: "and she asks me, do I want to go for it . . . but you feel the trust every time you go in there, you get more comfortable, more relaxed, and you're willing to go . . . into the dark areas."

The client generally viewed the therapist in a very positive light, as a "sounding board", as "being there" in the right place at the right time, as a gentle "guide", and as a respective, collaborative partner in the client's struggle. One client stated, " . . . he's someone . . . that I . . . don't know what I would have done without him . . . I really don't."

(2) Importance of a positive therapeutic atmosphere to client change and progress.

Clients identified a direct relationship between therapy efficacy, in terms of positive outcome and improvement, and the nature of the therapist's approach and the therapy setting. A safe, supportive therapy environment resulted in client attendance, motivation, openness, and initiative for change. One client described her therapist's approach and the therapy setting in the following way:

> . . . just the way he deals with me . . . as a therapist, [I] have found him extremely helpful because . . . his nature or his way . . . it's an extremely safe environment, and it's . . . one where I can just clear up whatever's been held back all this time . . . I see him . . as . . . one would a good friend.

Therapy was also viewed as the client's sanctuary, a place where it was " . . . enough to just sit there . . . a safe place." Therapy work commenced only when the client felt safe, ready and supported.

(3) Trust and safety: The cornerstones of congruence in therapy.

This theme reflects the importance of the client's development of trust and safety in the therapist and in the therapy relationship. The therapist was perceived as gauging his/her approach and techniques to suit the individual client in order to create an atmosphere of trust and protection. Therapist respect for the client's pace, degree of distance in the relationship, and prerogative over the process of change was valued by the client. One client described the development of trust as:

> . . . there's nothing that he could have done to gain my trust any faster than he did . . . I just knew right off the bat that I had to do [it] on my own speed . . . I didn't really want him to do anything to like push his trust on me . . . just let me go at my own speed.

When the client's struggles and difficulties were validated by the therapist, the client became increasingly willing to take risks and to confront core issues: " . . . his validation and his affirming . . . I knew it'd be a long and hard road, and there'd be some very unpleasant times . . . but to get through it." The client also assigned value to a therapist attitude of sincerity and practicality, in one client's words, his therapist "sees things . . . for what they are."

Chapter 5: Discussion

The discussion of the results and implications of this study will encompass seven sections: a comparison of the clients' and therapists' experiences of resistance; the elucidation of a "common thread" of therapist and client themes; the formulation of a new definition of psychotherapeutic resistance; the implications of the present study for the concept of resistance and for psychotherapeutic research; a comparison of the new definition with the "old" definitions; the limitations of this study; and, the implications for future research in this area.

Comparison of the Client and Therapist Results

The results of the data analysis indicated both parallels and inconsistencies in the comparison of the combined clusters of therapist themes and client themes. This comparison highlighted three different aspects of the experience of resistance in psychotherapy: the experience of the psychotherapeutic resistance itself, the experience of the process of psychotherapy generally, and the experience of the force opposite to resistance, the flow and progress of psychotherapy. All of these aspects of the experience of resistance were included in this discussion because it was important to the description of this experience from the many different perspectives of the participants.

The following discussion of the results of this study should be qualified by the fact that the nature of these particular therapy relationships was long-term, that is, the therapists and clients had been involved in their work together for at least one year. As noted earlier, in the methods chapter, this qualification has certain implications for the results obtained. For example, the participants' descriptions of their experiences were influenced by the stage of therapy, the relationship developed with the therapist, and the issues which they had already addressed. All of these factors have a different effect in the context of long-term therapeutic work than they would in terms of a short-term or time-limited therapy contract.

Similarities and differences between the two groups

In the comparison of first- and second-order clusters for all four therapists and all four clients in the study, there exist several similarities (Table 3, p. 57). The first similarity highlights the experience of resistance. Both clients and therapists experienced

Table 3: Similarities and Differences in Therapist and Client Themes

Similarities	Differences
Resistance as a paradox	Psychotherapeutic process/change (Clients) Resistance (Therapists)
Client mastery and control	Self-focus (Clients) Other-focus (Therapists)
Incongruence in therapeutic relationship	Language: blocked/stuck (Clients) Language: resistance/reluctance (Therapists)

resistance in therapy as a paradox, an entity which has both positive and negative connotations and functions. Clients and therapists perceived resistance as negative in the classical sense of its ability to impede therapy and progress and in its function as non-compliance with therapeutic directives. The positive aspects of resistance are that it serves as both an expression of the client's struggle and as the client's self-protective mechanism. These functions allow the client to maintain his/her integrity and a sense of control over the process and direction of therapy. Another positive perspective of resistance which both clients and therapists expressed was that it is a necessary and integral part of therapy; there is no forward movement without resistance.

A second similarity in client and therapist themes reflects the experience of psychotherapeutic flow or progress, the opposite force to resistance. This similarity was identified in terms of the client variable of mastery or competence as significant to psychotherapy. The mastery of the client's own process, and of the nature, pace and direction of therapy, is a key component to the general process and function of psychotherapy. The bottom line is that therapy exists for the client, not the therapist, and given that basis, client variables, such as mastery, are essential to how and why therapy works.

The third, and possibly most important, similarity in the themes from the two groups of participants is the idea of incongruence. This similarity reflects the last aspect of the experience of resistance, namely, the experience of the psychotherapeutic process. Incongruence refers to a misaligned match between client and therapist. The therapist's interventions, style and approach do not "fit" the client's needs, issues, and level of functioning. Therapist and client are working on two different wavelengths.

According to therapists and clients in this study, when such incongruence occurred in a therapy relationship, the result was resistance, stalled therapeutic work, and an impasse in the therapy process. In addition, this incongruence could also, at times, lead to conflict, client feelings of being discounted or minimized, and the end of the therapy contract. Incongruence is equivalent to therapy which is "stuck", and the therapist has to utilize his/her own or the client's resistance to monitor the level of incongruence.

There were three major differences in the ways in which therapists and clients experienced resistance in therapy. The first difference was that clients focused more on the experience of the psychotherapeutic process, in terms of the relationship with the therapist and their perceptions of the therapy setting, whereas therapists focused more on the experience of resistance, in terms of how it manifested in both the client and therapist and its effects on the therapy. The clients emphasized the foundation and process of therapy and concentrated less on resistance and other specific aspects of the workings of therapy. The clients were in tune with the bigger picture whereas the therapists, though they saw some of this picture, tuned in to the specific details. In addition, the clients seemed to focus more on the positive aspects of therapy and resistance--many of the client themes related to a positive perspective of therapy or the therapy relationship.

One possible reason for this difference is that therapists may be more focused on outcome and clients may be more focused on process and relationship. Therapist and client perspectives are different, in part, because therapy is viewed as a place where clients come to resolve their problems, and therapists are supposed to be the facilitators of change. For many clients, however, positive outcome may not be as important as the process of working through their problems or the relationship formed with another person, the therapist, during this process. Therapists may be subscribing to a North American or Western view of problem-solving, whereas clients may be more influenced by the Eastern culture or feminist perspective of the means being an end in themselves.

A second difference in how these two groups of participants experienced resistance is that clients seemed to be more self-focused in the exploration of their experiences whereas therapists seemed to be more other-focused. The clients' perspective of resistance was more one-sided as they explored only their own experience and tended to take full responsibility for the resistance or blockage of the therapy process. Therapists tended to explore both the clients' and their own experiences, but usually focused more on the client's resistance than their own. Again, a logical explanation for this finding is the fact that therapy is about the client, not the therapist. However, this difference may also be explained by the power differential which exists in the therapy setting, and the consequent client deference to the therapist which may result.

The third difference between client and therapist themes is the language utilized by the two groups in describing their experiences of this concept. Clients continued to use the language which I introduced to them, namely, the words "blocked" or "stuck" to describe the resistance. Therapists, however, tended to mix these words with "resistance" and "reluctance". Part of this difference seems to be that therapists continued to rely on the theoretical construct of resistance, and its classical definition, despite the different wording presented to them by the researcher. This difference is important because of the effect of language on how we think about things, and because how we think about things reflects back to the language we use. The words "blocked" or "stuck" imply a more passive process, external to the person, whereas the words "resistance" or "reluctance" imply an internal and active process.

The Common Thread

In this study, the common thread which unites the various client and therapist descriptions of their experiences of resistance is incongruence. This theme reflects the essence of the phenomenon of resistance in psychotherapy as experienced and described by the four client-therapist pairs. Resistance in psychotherapy appears to occur when there is a misalignment of the process or therapeutic structure between therapist and client. This misalignment may be visualized as two waves with different frequencies; their movements are not synchronous. The asynchronicity of this movement seems to best explain how resistance was experienced by these participants.

When the therapy became stuck or stalled, clients described how their process, at that moment, was not congruous with what they perceived their therapists' process to be. Therapists also described their experiences in much the same way; they often expressed that they were not moving "in synch" with their clients. The common thread of incongruence between therapist and client also relates to the other aspects of the experience of resistance as described in this study. For instance, the ebb and flow of the process of resistance is linked to incongruence because it is through these forward and backward movements that client and therapist are attempting to realign with one another, to become "in synch" or readjust to the frequencies of each others' wavelengths, so to speak.

A New Definition of Resistance

As noted in the literature review, many different definitions and models of resistance exist in both the theoretical and clinical literature. If the sheer volume of writing about this concept is any indication of its significance within the theory and practice of psychotherapy, resistance may be interpreted as a central and powerful influence on how we think about and act within the context of psychotherapy. Whereas some authors (de Shazer, 1984, 1989) have argued against the usefulness of this concept, this study maintains that resistance continues to have value for the understanding of the process of psychotherapy.

The present study, therefore, attempted to explore resistance by utilizing a research design and method which was expected to access the meaning of resistance from the perspectives of both client and therapist. The experiences of each group were then compared. This design was implemented within a qualitative, phenomenological research method because a research topic, such as the process of psychotherapy, was believed to be most accurately and completely accessed only through the exploration of the clients' and therapists' actual experiences.

One of my presuppositions in commencing this research project was that resistance is a psychotherapy process variable, something which occurs between the client and the therapist. In addition, this study focused on resistance in the exclusive context of psychotherapy. This focus was not, however, meant to suggest that resistance is an end result of psychotherapy. Resistance is a phenomenon which may be experienced before and after psychotherapy, with other people aside from the therapist, and within various contexts, including medicine and other health science disciplines (Rissman & Rissman, 1987).

A new definition of the concept of resistance has evolved as a result of this study and the participants' candid expressions of their experiences of resistance in a psychotherapy session. This new definition includes both a way in which resistance may be conceptualized, as well as some broader ideas about the process of therapy and the context of the therapeutic relationship. This wider angle on resistance is encompassed within the new definition because I discovered, in the process of being engrossed in this

research, that resistance cannot be separated from therapy; they are intertwined and interconnected like the threads of a cloth.

At one point during the data analysis, I found myself feeling as though I was off track from my topic because many of the client and therapist themes seemed to reflect the process of psychotherapy more generally, rather than only the specific aspect of resistance. It was at that moment that I came to the realization that resistance cannot be separated from therapy and examined under a microscope. It must be explored within the context of therapy and the interpersonal relationship between client and therapist.

Resistance, then, is defined as those moments in therapy when the process or work of therapy is somehow "stuck" or "blocked"--it occurs when the flow and forward movement of the therapeutic process temporarily slows or reverses. In this form, resistance is not an entity within either the client or the therapist, but rather it is a result of the interaction of these two people within the context of therapeutic change. Resistance is a natural and necessary phenomenon, an integral part of therapy, relationships, and change. From this perspective, resistance is seen as an interactional force operating within the client-therapist system. Basham (1992) discussed the interactional factors which influence resistance, such as family patterns, including distancing, conflict, underfunction/overfunction, and projection, as well as family structure and processes, including power, boundary, intimacy and rituals.

The story of one client-therapist pair of participants will be used to illustrate resistance as a blockage of the psychotherapeutic process. The client, Terrence, initiated therapy to address issues of depression, lack of motivation and direction in his life, and marital difficulties. He had previously been in therapy on four separate occasions and terminated the last therapy contract because of a disagreement with the therapist about Terrence's view of his wife. Terrence described his current therapist, Margaret, as sincere, practical, and a good match to his way of thinking. He also talked about having made some concrete and real progress as a result of this psychotherapy and the medication which he was taking for his depression.

In relating his experience of being blocked or stuck in a psychotherapy session, Terrence described struggling to confront the difficult and painful "core" issue, his

ambivalent relationship with his wife, which he felt to be germane to many of his other problems. He stated that, in the current psychotherapy, he had worked through most of the other issues related to his depression and lack of direction, such as his relationship with his parents. However, he identified wanting to avoid dealing with the "core" issue, and consequently found himself backtracking to the already-resolved issues or sidetracking to tangential issues. Terrence reflected that he has recognized this avoidance, and the resulting blockage, as a self-protective mechanism. Terrence stated that he is now more able to accept this avoidance as part of his own unique process because the actual progress he has made with his current therapist allows him to trust that sometimes change is slow.

The therapist of this pair, Margaret, described both her experience of Terrence's blocks in psychotherapy and her own feelings about a blocked psychotherapeutic process. Margaret is an experienced psychotherapist who has been practicing for about nine years and who uses a psychoanalytic approach, influenced by object relations theory. She described Terrence's blockage in psychotherapy as resulting from his particular personality style, the painful nature of his issues, and the transference relationship with herself. Margaret saw Terrence's blocks as occurring in two aspects of the psychotherapeutic process: in starting the discussion at the beginning of sessions and in continuing his work outside of session. Margaret stated that she experienced Terrence's blocks as very resilient and as present despite his motivation and a positive therapeutic relationship.

Margaret experienced feelings of frustration and helplessness, as well as her own blockage, in response to the discontinuous and often stalled nature of the psychotherapy and to Terrence's seeming inability to take what he learned in session and apply it outside of session. Margaret utilized these feelings by translating them into interventions to help Terrence process what was occurring in session and to remind herself of the uniqueness of every client's process.

Inherent in the new model of this "old" concept is the implication that resistance is a dynamic, process variable. Rather, resistance may be seen as ebbing and flowing throughout the course of therapy. Seligman & Gaaserud (1994), in surveying therapists about their experiences with resistance, found that most therapists perceived resistance

" . . . as a process that ebbs and flows throughout the counselling relationship" (p. 35).

This ebb and flow reflects the client's struggle to confront difficult issues and to address both the push towards change and the pull towards stasis. Simultaneously, it reflects the therapist's attempts to struggle along with the client and to move the therapy forward so that change can eventually occur. Within this ebb and flow of resistance, there is also the implication that resistance functions in the best interest of the client, and thus the best interest of the therapy, by acting as a mechanism for client mastery, integrity, and self-protection.

Another client-therapist pair of participants well illustrates this phenomenon of resistance as ebb and flow. The client, Samantha, began psychotherapy because of active suicidal ideation and depression. She was a single woman who had previously been in therapy with a psychiatrist. Samantha described her process in psychotherapy as a push-pull struggle between different parts of herself: one part that advocates change versus another part which insists on stasis. This inner struggle, Samantha said, was what often prevented her from talking or working with her therapist. It led to her being stuck because she would be fighting this inner battle and be unable to describe it verbally to her therapist.

In addition, Samantha described herself as very self-critical, which also played into her remaining stuck in session, because she would chastise herself for becoming and remaining stuck. She often commented on how her thoughts would sound "stupid" to anyone else. Thus, Samantha's blockage was a vicious cycle: the more confused and blank she felt inside, the more verbally stuck she would be on the outside, which fed into the confusion, and so on. Samantha also identified her struggle to accept her slow pace and the back-and-forth nature of her psychotherapeutic process as important issues.

Samantha's therapist, Doug, is a clinician with more than fifteen years of experience who works from an experiential approach, with a systemic and analytical theoretical basis. Doug experienced Samantha's ebb and flow resistance as a push-pull struggle between stasis and change, and saw his role in this struggle as providing non-judgmental respect and a middle ground for both sides. He reframed this struggle to Samantha as "competing forces" which exist within her and which are both working in her

best interest. Doug allied himself with the part of Samantha which he felt would help to overcome the blockage or "stuckness" in session.

Doug explained that he also examined his own role in Samantha's ebbing and flowing process and the ways in which he has helped her to both move forward and backward. He experienced compassion and sympathy for her struggle, and he saw her as wanting to change. Doug stated that he is very respectful of any direction which Samantha's process may take and that he attempts to intervene or support in any manner which is helpful to her.

The ebb and flow metaphor developed in this definition of resistance parallels Mahoney's (1991) discussion of the oscillative dynamics in the process of change. Mahoney develops the idea of oscillation by noting that these forward and backward movements (as in waves or the swing of a pendulum) are a natural phenomenon which occurs in virtually every area of human life: " . . . dynamic variations are pervasive in all human experience" (p. 333). He highlights the fact that human lives change from moment to moment even though we try to discover and maintain some stability and middle ground to these oscillations. In attempting to move forward, we inevitably encounter resistive forces and move backward (Mahoney, 1991).

The idea of discovering a middle ground to this ebb and flow, or to these oscillations, in this new model of resistance is also reflected in Bernstein and Landaiche's (1992) conceptualization of resistance. They postulate resistance " . . . in terms of a homeostatic balance--the ability to respond to changes and encounters in the environment and to flexibly maintain self-integrity" (p. 9). Thus, balance is seen as a range around a central point which lies between two extremes. Balance involves a dynamic process of movement, which encompasses various options and possibilities, around this central point in response to social and environmental variables (Bernstein & Landaiche, 1992). The authors claim that adherence to either extreme, as well as to the central point only, is unhealthy. Psychological health is achieved through balance, which " . . . is maintained through constant readjustment" (Bernstein & Landaiche, 1992, p. 9). The flavor of this description captures some of the essence of the new model of resistance offered as a result of the present research findings.

Enlarging the field of vision shifts the focus from resistance to highlight the therapy relationship between therapist and client. This relationship was a significant variable in both the client and therapist themes resulting from the data analysis. The major theme which evolved out of the client and therapist accounts of their experiences is incongruence. Incongruence refers to the dystonic match between the therapist's and the client's individual processes and their combined process in the therapeutic relationship. It is this combined process which must ultimately function to advance therapy towards some final goal, whether this goal is process- or outcome-oriented.

As evidenced in the comparison between the two groups of participants, clients repeatedly reflected on the importance of their therapist's style or approach and how that fit with their process, issues, and ways of understanding. Similarly, therapists reported matching their therapeutic approach to the stage of therapy, the client's process, and the client's current level of functioning. When incongruence occurs within a client-therapist relationship, the result is resistance. When congruence is achieved, the result is a positive experience for the client and, often, a positive outcome to the therapy.

A third client-therapist story illustrates the theme of congruence. The client in this pair, Maureen, was referred for psychotherapy to augment medical treatment which she was receiving for an illness. The chronic nature of this illness meant that Maureen had been in contact with many health professionals over a long period of time. Maureen described often feeling discounted and belittled by these professionals because no physiological basis for her illness could be found. She consequently distrusted most professional health care workers.

In describing her relationship with her therapist, Maureen painted a different picture. She stated that she trusted her therapist and that she felt safe in the psychotherapeutic setting. Maureen also described her therapist in a very positive light, as being compassionate, caring, dependable, and an expert. This positive perception of the therapist and the therapy setting led to Maureen's ability to gradually address and work through her difficult issues within the psychotherapeutic context. Only because she felt respected by the therapist, who utilized a collaborative approach, was Maureen able to take these risks in psychotherapy.

Maureen's therapist, Jane, is a cognitive-behavior therapist with more than ten years of experience in psychotherapy with medical patients. Jane recognized the importance of allowing Maureen to tell her story, while she took a supportive role, in order for psychotherapy to succeed. She perceived Maureen as resistant to working within a psychological framework so she experimented with various therapeutic styles to find the best one to suit her client. Jane continually encouraged Maureen to pursue all treatment options offered to her, and she attempted to aid Maureen in bridging the transition between in-session learning and outside of session coping. Jane concluded that a combination of support and intervention was most effective to foster a positive therapeutic relationship.

This description highlights two important corollaries to the theme of congruence. The first corollary concerns the issue of agendas in therapy, namely, who determines the therapeutic agenda. Ideally, the therapist and client work together when therapy begins to determine the direction therapy will take so that " . . . the encounter between the therapist and client moves consistently and freely, back and forth between each individual's agenda . . . " (Bernstein & Landaiche, 1992, p. 9). However, often during the course of the actual therapy, either the client's or the therapist's agenda (which may not necessarily be one and the same) may take precedence, resulting in incongruence. This situation was described by the participants as arousing resistance or blockage in the therapy session.

The second corollary to the theme of congruence is the issue of pacing within the individual session as well as within the therapy overall. Several of the participants addressed this issue in terms of their own process and of the therapeutic progress. Therapists tended to express some degree of frustration or concern over their clients' slow pace and progress in therapy, but they usually dealt with this concern directly, by asking the client for feedback about the direction and pace of therapy, or indirectly, by adopting an attitude of acceptance, so this seemingly slow pace was seen as congruent to the client's process.

The last aspect of resistance revealed in the client and therapist themes is at the broadest level of analysis so far, the therapy itself. Both client and therapist accounts indicated themes which focused on the context and process of therapy generally. There

were numerous client themes which highlighted issues such as the safety and trustworthiness of the therapy atmosphere and setting. This emphasis seemed to indicate that the establishment of a strong foundation, in terms of the creation of a safe environment by the therapist, was essential to the client's trust in the process of therapy, and, ultimately, in the working through of difficult issues. Therapists reiterated some of these themes, but seemed generally to be more interested in exploring the concept of resistance and the specific aspects of its functioning within the therapy environment.

Implications of this Study for Resistance and Psychotherapy

The findings of this study have several implications for the concept of resistance and for the practice of psychotherapy. This study has shown that no matter how we define this complex concept, either theoretically or empirically, resistance is an important psychotherapeutic phenomenon. It is perhaps not a central component as it once was in the past, especially under Freud's influence, but it is definitely an aspect of therapy which has meaning for both clients and therapists, as indicated by the present research. Furthermore, resistance is a natural part of change, and thus virtually all human activities which involve change. It is a necessary and healthy phenomenon which allows control over the nature, process, and pace of change. Resistance is, therefore, worth studying in order that we may understand it and utilize it more effectively.

I believe that this study has highlighted the possibility of a new perspective of resistance as a phenomenon in psychotherapy. Previous perspectives of resistance as a negative force within the client, which is ever-present and must be confronted by the therapist, may be outdated in our present understanding of the psychotherapeutic change process. With the advent of a "new wave" of therapies, which advocate a collaborative therapy relationship, and the more widely accepted definition of resistance as a self-protective mechanism (Mahoney, 1991), the former adversarial stance of therapy, and its view of resistance, is no longer necessary or healthy.

The new outlook on psychotherapy does not, however, necessarily mean that we must abandon the concept of resistance, but that we need to adopt " . . . a therapeutic attitude of working with the client and communicating that attitude to the client [which]

will permit significant improvement in ways of helping clients . . . " (Lewis & Evans, 1986, p. 431).

Another implication of the present study is the significance of its re-definition of resistance as a continually ebbing and flowing process within the therapy and the therapeutic relationship. This finding should signal therapists to increase their acceptance of the ways in which the therapy process moves, sometimes forwards, sometimes back, and that this movement is not without purpose. It is in fact the natural rhythm of human life and the change process (see Mahoney, 1991). Therapists should also be alerted to the fact that, at times, they may be too focused on outcome, and not sufficiently focused on process, with which clients seem to be more in tune. This finding indicates that therapy becomes "stuck" or "blocked" for a reason, and that often that reason is related to the client's process.

This study sends a strong message about the importance of client-therapist congruence in determining the nature, course, and pace of therapy. In exploring their experiences, clients and therapists alike emphasized that incongruence, between the therapist's style and interventions and the client's way of understanding and processing the information, most often led to resistance. This study implies that the key to "good", successful therapy is a balance, or a re-alignment, between therapist and client processes and agendas.

The "New" vs. the "Old" Definitions of Resistance

The new definition of resistance arrived at in this study makes an interesting comparison to the "old" definitions, namely, those definitions influenced by Freud and the psychoanalytic thinkers. Freud and psychoanalysis focused on resistance as an intrapsychic, or intrapersonal, entity. Freud did not ascribe an interpersonal component to resistance. The "old" definition of resistance can be summarized in Freud's own words,

> the patient, who is suffering so much from his [sic] symptoms and is causing those about him to share his sufferings, who is ready to undertake so many sacrifices in time, money, effort and self-discipline in order to be freed from those symptoms--we are to believe that this same patient puts up a struggle in the

> interest of his illness against the person who is helping him (Freud, 1916/1963, p. 286).

In examining this definition, it is evident that the "old" model of resistance emphasized its intrapsychic, unconscious, yet deliberate, and destructive nature. Resistance is something within the patient, it operates unconsciously, yet at the same time, the patient is perceived as willingly engaging this force, and it is perceived as a negative energy, a force preventing the psychotherapy from proceeding as the therapist envisions. After all, Freud built the empire of psychoanalysis on the foundation of resistance. For the analyst to overcome the patient's resistances is the "essential function of analysis" (Freud, 1916/1963, p. 291).

Although there are many aspects of this definition which are unpalatable to most psychotherapists today, one should not, as the old saying goes, throw the baby out with the bath water. As noted previously in this paper, the intrapersonal aspect of resistance was not addressed in the present research. Rather, the interactional aspect of resistance was highlighted. However, I believe that there is merit to including both aspects within a well-rounded definition of resistance. Psychotherapy is always a process between people, but within that process, each person has his/her own experiences and his/her own "covert world" (Rennie, 1990, 1992), which may or may not be shared with the other person. Thus, Freud's lasting contribution to the definition of resistance is his focus on the intrapsychic aspects of this complex phenomenon.

The new definition of resistance developed in this study presents a different perspective of the phenomenon of resistance than Freud's original definition. As in narrative, and several other schools of psychotherapy, in this new model resistance always serves an important function within therapy: it serves as a reminder to both client and therapist to re-examine and re-adjust their approaches to each other. This new definition signals a new direction in how we see change and non-change within psychotherapy and outside of psychotherapy.

Limitations of the Study

There are several limitations of the present research study, most of which are a result of the research design and method. One limitation of the research design was that only one meeting was conducted with the research participants, which served as both introduction and interview. Though I did speak to each participant over the phone before our initial meeting, the interview itself had to serve the dual function of establishing rapport (including trust and the assurance of confidentiality) and data collection. This design was not optimal for a phenomenological research study because the one function, establishment of rapport, at times interfered with and compromised the other function, data collection.

This limitation seemed to most effect the client interviews because of the rapport issues mentioned above and the power differential in the therapeutic relationship which inevitably makes clients more vulnerable in terms of trust and confidentiality. The limitation was less of an issue with the therapists because I knew two of the four therapists prior to the study, and it did not seem to take long to establish a connection with the other two at the beginnings of our interviews together.

Another design limitation of this study was the way in which language was utilized, by the interviewer and the participants, to describe the experience of resistance. As discussed above, the use of language both reflects and affects the way in which we think about things. Thus, I had intentionally phrased my research question using the words "blocked" or "stuck", not "resistant", because I did not want the research participants, especially the therapists, to be influenced by pre-conceived ideas about, and theoretical frameworks or classical definitions of, resistance. Unfortunately, the therapists often did return to using the word "resistant" which may have effected the reports of their experiences.

The method of client selection in this research design was also a limiting factor. Bias is inherent in this design, in which therapists selected a client from their caseload whom they deemed appropriate for this research. Again, by the nature of the long-term therapy in which they were engaged, therapists very likely selected clients with whom they had developed a positive working alliance.

One methodological limitation of this study concerns the validity of verbal reports as data. In this study, participants were asked to reflect on a therapy session, which had just occurred, and relate their experiences of this session, generally, and of any resistance encountered, specifically. There are many issues which contribute to the questioning of the validity of this type of approach, including the accuracy of the participants' recall, the degree to which participants censor or alter their relation of this recall, and the influence of the interviewer on both the participant's recall and relation.

In terms of the accuracy of the participants' recall, the research approach utilized, qualitative-phenomenological, and the experience assessed, resistance, induce us to accept the participants' recall of their experiences at face value. In attempting to understand the meaning of other people's experience, the phenomenological research method was chosen as the most appropriate because it seems most logical to ask the people themselves to describe their experiences, thus we have no choice but to accept the risk of inaccuracy of verbal reports along with the benefit of tapping directly into a person's experience (see Rennie, 1994).

In terms of the participants' alteration of their recall, the issue is whether participants simply recalled their experiences or whether these experiences were elaborated on and mixed with their experiences during the research interview itself. This issue was addressed in the present study by reminding participants, throughout the interview, to reflect on their experiences of resistance in the therapy session. However, it can be argued that there is always a certain degree of construction of the experiences present along with their recall (Rennie, 1990, 1992).

Lastly, the issue of the influence of the interviewer on the participants can be circumscribed by noting that the interviewer intended to conduct an open-ended interview, wherein participants were free to explore their experiences with the least amount of outside influence. The interviewer, however, took a more active, "co-constructing" stance when it was deemed necessary, such as when a participant seemed to be struggling with the expression or recollection of an aspect of his/her experience. Rennie (1990) addressed this issue by stating that "the research participant's representation of experience invariably occurs in a social context and is influenced by it" (p. 168). Thus, we cannot separate the

participant's representation from the context of that representation, which includes the interviewer and her influence.

A second methodological limitation of the study, which is related to the above limitations, concerns the degree to which both therapists and clients were open and honest about their process and experience of resistance in the session. The therapists may have been confined by their theoretical orientations and the framework of psychotherapy. In addition, many therapists are not accustomed to reflecting and candidly speaking about their own process within the psychotherapy session. Therefore, most therapists tend to rely on the framework of their theoretical beliefs and background which may interfere with a true reflection of their process.

The clients, on the other hand, have a different issue to contend with, namely, the risk of revealing too much in a research interview for fear of its repercussions on their therapy. Despite reassurance of the confidentiality of the research interview, most of the clients seemed apprehensive about their reflections to the interviewer. This apprehension is quite natural considering their position, which has less power within the therapeutic relationship, and even within the interview relationship. It was also understandable in terms of the one-time meeting with the interviewer. The phenomenon of client deference to the therapist (Rennie, 1990) seemed to come into play because all of the clients appeared reluctant to say anything negative about, or criticize, their therapists. If this deference did occur, it would have affected what and how much the clients revealed to the interviewer.

A third methodological limitation, which must be considered in this type of research, is the effect of any unresolved therapist issues on the client's process and the therapy overall. This issue was not explicitly explored with these therapists although several of them mentioned that they attempted to be aware of the interference of their own issues in the client's process, especially when they felt some resistance in the session. They stated that they self-reflected at these moments to discover what role their own issues was playing in the occurrence of the resistance.

Implications for Future Research in Resistance and Psychotherapy

The present research study has several implications for the direction of future research in the areas of resistance and psychotherapy. The first implication concerns the research method utilized in this study. I firmly believe that a phenomenological research method, within a qualitative framework, is the most appropriate one for assessing psychotherapy process variables, such as resistance. As has been noted numerous times throughout the presentation of this study, the concept of resistance is a complex one, and as a result, it contains rich data about the process of psychotherapy and the interpersonal relationship between therapist and client. A phenomenological research method taps into the meaning which people ascribe to phenomena which they experience. Quantitative methods have attempted, over the years, to measure, define, and assign a number to the concept of resistance, but have failed to tap the essence of this concept, what it means to the people who engage within a therapeutic relationship. Rennie, Phillips, and Quartaro (1988) commented that the qualitative, phenomenological " . . . approach yields access to aspects of human experience which are difficult, if not impossible, to address with traditional approaches to psychological research yet are inherent in the subject matter of psychology" (p. 147).

A second implication of this study concerns the future direction which psychotherapy process research, specifically in the area of resistance, could explore. This direction could incorporate similar designs as the present study and address the design limitations in terms of the research interviews and the language utilized in assessing and describing resistance. Future research could also implement a tape-recall procedure, similar to that used by Rennie (1990, 1992, 1994) and others, to stimulate the participants' recall of their experience of resistance. This technique may aid in focusing the participants more on their recall of the experience, and less on the experience of the interview itself, and it would also allow the interviewer to actually hear the process between client and therapist in session, rather than receiving a second-hand account of the process.

Future research endeavors could expand on the present study by including a larger number of research participants and varying both the therapist theoretical orientations, training, and approach to therapy, and the client backgrounds and presenting issues. I

believe that the design of the data analysis, which consisted of a between-groups comparison, was a useful one and yielded some important information which would have been missed had client-therapist pairs not been utilized in the study.

An interesting aspect of the present study, which was unanticipated in the original design, was that therapists tended to choose their most "stuck" or "blocked" clients for the research interviews. In addition, several of the therapists commented on the fact that the research interview helped them to process some of what was happening for them in session with these clients, especially around issues of resistance. One therapist, in fact, commented that I, as the research interviewer, was like a therapist to the therapeutic relationship, in the same way that a marriage therapist is to a couple in therapy. The influence of the researcher on client and therapist participants in studies such as this one, which explore the process of psychotherapy, is not an area which has been widely examined.

At the beginning of this research study, my goal was to discover the "essence" of the experience of resistance in psychotherapy. Having read the literature in this area, I felt that there was something missing, something which clarified what resistance really was, how it felt in the actual session. This impression led me to incorporate a phenomenological approach to study, and then attempt to describe and understand, this complex phenomenon.

The main bias which I brought to this study was my focus on the interpersonal aspect of the experience of resistance. I was working from the assumption that resistance is a systemic process within therapy. As noted previously, I do not feel that this limited the participants to describing only the interpersonal aspects of this experience because the questions I asked were open-ended in terms of providing either an intrapsychic or an interpersonal context for the experience.

My presuppositions did, however, influence the "common thread", or essence, which I discovered from the results of this study. This common thread emphasizes the interpersonal, systemic aspect of resistance, namely, it views resistance as incongruence between client and therapist. Thus, while not negating the importance of the intrapsychic component of resistance, nor its existence outside of psychotherapy in virtually all human

activities, this new perspective does highlight a part of this complex experience, within a unique setting, therapy, which has received little attention in the past. And it is this highlighting of at least part of the essential experience of resistance which I believe was both the most important learning I gained from this research, as well as the most significant outcome of the study. I hope that I will take this new-found knowledge and understanding with me, and practice it, as I move forward as a therapist and as a person.

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Appendix A

Verbal Presentation (Therapists)

Hi, my name is Diane Priebe. I am a Masters of Education student in the Department of Educational Psychology at the University of Alberta. For my Master's thesis, I am doing a qualitative study of therapists' and clients experiences of becoming "blocked" or "stalled" in a therapy session. A qualitative interview method will be used in order to allow you to explore and reflect on your thoughts, feelings and reactions to being "stuck" in a therapy session with your client. The results of this study will be published as my Master's thesis.

By interviewing you, I hope to increase my understanding of therapists' experiences of becoming "blocked" in a therapy session and their reflections on their inner processes in the context of their interpersonal relationship with a client. My interest in this area stems from both professional and personal sources. Professionally, I have become interested in therapists' different approaches in dealing with being "blocked" in therapy. Personally, as a therapist-in-training I want to further explore my own experiences of this phenomenon.

Your participation in this study will involve two interviews. During the first interview we will become acquainted with one another and share some of our backgrounds. After I have explained the nature and purpose of the study to you, informed consent will be discussed and obtained from you. Also, during this first interview, I will ask you to describe in as much detail as possible your experience of being "blocked" in a session with a client. This first interview will be tape recorded and will be approximately 60 minutes in length. This tape recorded interview will be transcribed using pseudonyms for your name and any other names you may mention. Only myself and my supervisor (Dr. B. Paulson) will have access to the original tape, and following the study, the tapes will be erased. I will analyze the transcribed interview to determine the themes which represent your experiences of being "blocked" in therapy.

During the second interview, I will share and discuss my understanding of your experiences with you. This time will allow you to provide feedback that will support or refute my analysis. My data will be altered as a result of your feedback. After the study is completed and if both you and your client agree, I would be glad to share my findings with you.

Again, I would like to remind you that your participation in this study is completely voluntary and anonymous. Also, you may discontinue the study at any time without penalty. If you do decide to discontinue the study, all information about you will be destroyed. In addition, if your participation in this study raises any concerns, a referral for support and counselling will be offered. If you have any questions, please feel free to contact me at 433-6774.

Verbal Presentation (Clients)

Hi, my name is Diane Priebe. I am a Masters of Education student in the Department of Educational Psychology at the University of Alberta. For my Master's thesis, I am doing a qualitative study of therapists' and clients experiences of becoming "blocked" or "stalled" in a therapy session. A qualitative interview method will be used in order to allow you to explore and reflect on your thoughts, feelings and reactions to being "stuck" in a therapy session with your therapist. The results of this study will be published as my Master's thesis.

By interviewing you, I hope to increase my understanding of clients' experiences of becoming "blocked" in a therapy session and their reflections on their inner processes in the context of their interpersonal relationship with their therapist. My interest in this area stems from both professional and personal sources. Professionally, I have become interested in clients' different approaches in dealing with being "blocked" in therapy. Personally, as a therapist-in-training I want to further explore my own experiences of this phenomenon.

Your participation in this study will involve two interviews. During the first interview we will become acquainted with one another and share some of our backgrounds. After I have explained the nature and purpose of the study to you, informed consent will be discussed and obtained from you. Also, during this first interview, I will ask you to describe in as much detail as possible your experience of being "blocked" in a session with your therapist. This first interview will be tape recorded and will be approximately 60 minutes in length. This tape recorded interview will be transcribed using pseudonyms for your name and any other names you may mention. Only myself and my supervisor (Dr. B. Paulson) will have access to the original tape, and following the study, the tapes will be erased. I will analyze the transcribed interview to determine the themes which represent your experiences of being "blocked" in therapy.

During the second interview, I will share and discuss my understanding of your experiences with you. This time will allow you to provide feedback that will support or refute my analysis. My data will be altered as a result of your feedback. After the study is completed and if both you and your therapist agree, I would be glad to share my findings with you.

Again, I would like to remind you that your participation in this study is completely voluntary and anonymous. Also, you may discontinue the study at any time without penalty. If you do decide to discontinue the study, all information about you will be destroyed. In addition, if your participation in this study raises any concerns, a referral for support and counselling will be offered. If you have any questions, please feel free to contact me at 433-6774.

Appendix B

Written Presentation (Therapists)

I am a Masters of Education student in the Department of Educational Psychology at the University of Alberta. For my Master's thesis, I am doing a qualitative study of therapists' and clients experiences of becoming "blocked" in a therapy session. A qualitative interview method will be used in order to allow you to explore and reflect on your thoughts, feelings and reactions to being "blocked" in a therapy session with your client. The results of this study will be published as my Master's thesis.

By interviewing you, I hope to increase my understanding of therapists' experiences of becoming "blocked" in a therapy session and their reflections on their inner processes in the context of their interpersonal relationship with a client. My interest in this area stems from both professional and personal sources. Professionally, I have become interested in therapists' different approaches in dealing with being "blocked" in therapy. Personally, as a therapist-in-training I want to further explore my own experiences of this phenomenon.

Your participation in this study will involve two interviews. During the first interview we will become acquainted with one another and share some of our backgrounds. After I have explained the nature and purpose of the study to you, informed consent will be discussed and obtained from you. Also, during this first interview, I will ask you to describe in as much detail as possible your experience of being "blocked" in a session with a client. This first interview will be tape recorded and will be approximately 60 minutes in length. This tape recorded interview will be transcribed using pseudonyms for your name and any other names you may mention. Only myself and my supervisor (Dr. B. Paulson) will have access to the original tape, and following the study, the tapes will be erased. I will analyze the transcribed interview to determine the themes which represent your experiences of being "blocked" in therapy.

During the second interview, I will share and discuss my understanding of your experiences with you. This time will allow you to provide feedback that will support or refute my analysis. My data will be altered as a result of your feedback. After the study is completed and if both you and your client agree, I would be glad to share my findings with you.

Again, I would like to remind you that your participation in this study is completely voluntary and anonymous. Also, you may discontinue the study at any time without penalty. If you do decide to discontinue the study, all information about you will be destroyed. In addition, if your participation in this study raises any concerns, a referral for support and counselling will be offered. If you have any questions, please feel free to contact me at 433-6774.

Written Presentation (Clients)

I am a Masters of Education student in the Department of Educational Psychology at the University of Alberta. For my Master's thesis, I am doing a qualitative study of therapists' and clients experiences of becoming "blocked" in a therapy session. A qualitative interview method will be used in order to allow you to explore and reflect on your thoughts, feelings and reactions to being "blocked" in a therapy session with your therapist. The results of this study will be published as my Master's thesis.

By interviewing you, I hope to increase my understanding of clients' experiences of becoming "blocked" in a therapy session and their reflections on their inner processes in the context of their interpersonal relationship with their therapist. My interest in this area stems from both professional and personal sources. Professionally, I have become interested in clients' different approaches in dealing with being "blocked" in therapy. Personally, as a therapist-in-training I want to further explore my own experiences of this phenomenon.

Your participation in this study will involve two interviews. During the first interview we will become acquainted with one another and share some of our backgrounds. After I have explained the nature and purpose of the study to you, informed consent will be discussed and obtained from you. Also, during this first interview, I will ask you to describe in as much detail as possible your experience of being "blocked" in a session with your therapist. This first interview will be tape recorded and will be approximately 60 minutes in length. This tape recorded interview will be transcribed using pseudonyms for your name and any other names you may mention. Only myself and my supervisor (Dr. B. Paulson) will have access to the original tape, and following the study, the tapes will be erased. I will analyze the transcribed interview to determine the themes which represent your experiences of being "blocked" in therapy.

During the second interview, I will share and discuss my understanding of your experiences with you. This time will allow you to provide feedback that will support or refute my analysis. My data will be altered as a result of your feedback. After the study is completed and if both you and your therapist agree, I would be glad to share my findings with you.

Again, I would like to remind you that your participation in this study is completely voluntary and anonymous. Also, you may discontinue the study at any time without penalty. If you do decide to discontinue the study, all information about you will be destroyed. In addition, if your participation in this study raises any concerns, a referral for support and counselling will be offered. If you have any questions, please feel free to contact me at 433-6774.

Appendix C

Consent Form (Therapists)

I, _____, give my permission to participate in this study. I am aware that the study is being conducted as a part of Diane Priebe's Master's thesis for her Master of Education degree, under the supervision of Dr. Barb Paulson of the Department of Educational Psychology at the University of Alberta. I am aware that the purpose of this study is to understand therapists' experiences of becoming "blocked" or "stalled" in a therapy session with a client. Through the use of the interview format, I will be asked to describe my experiences in as much detail as possible. I understand that I will be participating in one tape recorded interview of approximately 60 minutes in length.

I understand that my consent is voluntary and that if I choose, I can discontinue my participation in the study at any time without penalty. Also, I am aware that my name, the names of other people that I may mention, and my place of employment will be replaced with pseudonyms so that it will be impossible to recognize me as a participant in the study. In addition, I am aware that Diane and her supervisor, Dr. B. Paulson, will be the only people with access to the tape recorded interview, and I understand that Diane will erase the tape recording after she has transcribed the interview.

Finally, I am aware that the information obtained from the interview will be used by Diane for the purpose of her study. Also, I understand that the results of the study will be published as Diane's Master's thesis. If I have any questions, I understand that I can contact Diane Priebe at 433-6774.

Signature: _____

Date: _____

Consent Form (Clients)

I, _____, give my permission to participate in this study. I am aware that the study is being conducted as a part of Diane Priebe's Master's thesis for her Master of Education degree, under the supervision of Dr. Barb Paulson of the Department of Educational Psychology at the University of Alberta. I am aware that the purpose of this study is to understand clients' experiences of becoming "blocked" or "stalled" in a therapy session with their therapist. Through the use of the interview format, I will be asked to describe my experiences in as much detail as possible. I understand that I will be participating in one tape recorded interview of approximately 60 minutes in length.

I understand that my consent is voluntary and that if I choose, I can discontinue my participation in the study at any time without penalty. Also, I am aware that my name, the names of other people that I may mention, and my place of employment will be replaced with pseudonyms so that it will be impossible to recognize me as a participant in the study. In addition, I am aware that Diane and her supervisor, Dr. B. Paulson, will be the only people with access to the tape recorded interview, and I understand that Diane will erase the tape recording after she has transcribed the interview.

Finally, I am aware that the information obtained from the interview will be used by Diane for the purpose of her study. Also, I understand that the results of the study will be published as Diane's Master's thesis. If I have any questions, I understand that I can contact Diane Priebe at 433-6774.

Signature: _____

Date: _____

Appendix D

Interview Questions (Therapists and Clients)

These questions are designed to gain data and insight into therapists' and clients' experiences of becoming "blocked" or "stalled" in a therapy session. The data gathered will be used to uncover themes that are common experiences to both therapists and clients in being "blocked" in a session.

For example:

1. When in the session did you feel "blocked"?

2. What were you thinking at that time? What were you thinking right before that? Right after that?

3. What were you feeling at that time? What were you feeling right before that? Right after that?

4. What did you think the client was thinking and feeling at that time? **(therapists)**

5. What did you think the therapist was thinking and feeling at that time? **(clients)**

6. What helped you to get "un-blocked", i.e. to get through and past the impasse in the session? Was it something that you felt/did/said to the client? Or something that the client did/said to you? **(therapists)**

7. What helped you to get "un-blocked", i.e. to get through and past the impasse in the session? Was it something that you felt/did/said to the therapist? Or something that the therapist did/said to you? **(clients)**

8. Was this a helpful or a hindering experience in the session for you? Did you feel that it was a useful experience for you and/or for your client? **(therapists)**

9. Was this a helpful or a hindering experience in the session for you? **(clients)**

10. How did this experience affect the course of the rest of the session?

11. Globally, in therapy so far, when has this happened before? What was the outcome or result?

Appendix E: Sample First Order Data Analysis of One Client's Experience of Resistance

Meaning Unit	**Paraphrase**	**Theme**
701. Yah, quite a bit, but a lot of it. . .is myself, just that there are times when. . .I know that it's a safe place to do so, but I kinda feel like I have to hold back and it's like, well, I don't know if I really want to tell anybody this, and so a lot of times he's gotta really dig, dig, dig and rip the bricks out . . .	Client identifies often feeling stuck and having to hold back despite safety of therapy; takes responsibility for blockage.	Maintenance of client's protective wall despite safety of therapy.
702. And so for a long time, we just dealt with that, to try and get me on an even keel and so then I wouldn't run out in front of a truck or something (pause), that was good 'cause. . .it kind of calmed me down. . .god, it's a long time. There are times when I feel frustrated because it's taking so long, I'm very impatient person sometimes.	Client feels frustrated and impatient with the length of the therapy process, despite recognizing the necessity of it.	Client frustration with slow progress.
703. It took a long time because I was not. . .feeling very stable, so I'd be up and down and all around. . .my guess is that. . .it's taken almost that whole time just to get kind of on an even, or enough so that I can start thinking about the causes . . .like why am I sad, why am I mad, I don't understand it all of a sudden. So now we're starting to . . . get more into that, it's slow though . . .	Client understands course of therapy: stabilization before the work on underlying causes can begin.	Importance of client stability for start of therapy work.
704. . . .it wasn't really a conscious thing, that, okay I feel fine now, let's go. . .even though it's hard to look at some of this stuff, but it actually, at the same time, it also makes me feel good in a way because it's like, oh, I feel like I'm getting somewhere now . . .	Client recognizes difficulty of process of exploring deeper issues, but also feels satisfied with perceived progress.	Paradox of therapy work: difficult exploration yields feelings of achievement.

705. . .and I. . .wonder if I was ready. . .to get there any sooner, if that makes any sense. . .a process, I guess. . .so it's still hard, and I still--I go and then back up, and go and back up . . .	Client's acceptance of the pace of her process and its back-and-forth nature.	Honoring the pace and changing direction of client's process.
706. I'm not looking at you. . .for some reason. . .if I look at a person. . .then I start thinking about what they're thinking, and I start thinking about how they're gonna to react, but if I don't think of them as actually--then I can just say, otherwise, I just start thinking, okay, well if I say that, they're gonna think that and then they're gonna, and then the therapy's not even working, so.	Client avoids eye contact in order to speak in a free, unedited manner.	Importance of client distance for uncensored dialogue.
707. If I'm looking at the person, then it's like they're another person, and I kind of have to separate him in like, he's not really a person, in one sense, he's just there, and he's the expert and, I can talk and he can. . .help me but. . .it's been a year and I still don't look at him. . .it just kind of separates them a bit . . .	Client views therapist as an expert, not as a real person, in order to separate herself from him.	Client need to see therapist in a professional, not a personal, role.
708. . . .there are times when I feel blocked that--I'm in the frame of mind of, well what am I doing here, I'm not getting any better, this is no good, more. . .dumping on myself, it's like I'm not even. . .a good enough patient, to be able to even do therapy right . . .	Client berates and blames self when blocked, for not doing therapy "right".	Client's self-blame for blockage.
709. . . .it sounds pretty stupid when you say it out loud, but that's what goes through my mind lots, and. . .so then I start analyzing stuff before I've even said it, which then leads me not to say anything, and I say, I don't know, a lot (laughs).	Client's monitoring of own process causes her to be silent or to say "don't know".	Client's intense self scrutiny results in verbal blockage.

710. . . .other times I'm afraid to say what's just popped into my mind. . .different reasons for the fear at different times, one that often pops in my brain as I'm talking is, well that sounds stupid. . .it just sounds dumb, and I don't wanna sound dumb.	Client identifies not wanting to verbalize her thoughts for fear of sounding "stupid".	Client fear of revealing inner process.
711. . . .there's other times when I just don't understand, I'm just confused and I don't really understand and then everything just kind of goes blank, and. . .he'll make suggestions and we'll try, but it's just, nothing is clicking, nothing feels right.	Client's confusion and lack of understanding cause her to go blank and become stuck.	Blockage results from client's confused, blank state.
712. I clung to this once a week appointment just because. . .if I didn't keep coming, I don't know, it was like my kind of like little life line. . .I was more thinking of just. . .the life line and. . .keeping afloat, keeping afloat, now that it's a little bit more afloat, it's like, okay, now I'm ready, let's go, wanna know, I wanna know, I wanna know (laughs).	Client feeling of stability leads to readiness to deal with deeper underlying issues.	Client's improved state results in desire to start work.
713. . . .one part of me says that there's still another part that I don't know if it does want to know. . .because then things shut down, I'll get somewhere, and all of a sudden it's like a big wall without even me realizing, just subconsciously, pum. Like those get-smart things where all the doors come down--that's what I think of when it happens, it's like phoom. And without me even realizing it or making it do that, consciously making it do that . . .	Client recognizes that part of her does not want to deal with deeper issues because she unconsciously stops her own process.	Push-pull struggle of different client selves: for and against change.

714. . . .so then I. . .get a little frustrated, it's like, come on. . .you're here, do some. . .I'm mad at myself for that happening, but I'm sure there's some kind of psychological mumbo-jumbo that deals with that.	Client becomes angry and frustrated with herself for blocking of her own process.	Client frustration with blockage of process.
715. . . .there were lots of times in that first several months where. . .I wouldn't talk, like, I'd just sit there. . .it was kind of like enough to just sit there, it's like--oh, this is a safe place. . .I can relax . . .	In beginning of therapy, client often felt comfortable to just sit and be silent.	Therapy as, initially, client's silent sanctuary.
716. . . .but then when I'd. . .be really into talking and then I'd get here, and as soon as the door closed, it would be like--I didn't want to talk. . .in a sense to me, that was like I just kind of blocked, but I don't know why. Ahm, and so it would take like a half an hour before he actually got anything out of me because for some reason all of a sudden, even though I'd been wanting to talk all week, as soon as I got there, it was like phoom . . .	Client becomes stuck once she enters therapy room--she no longer wants to talk.	Contrast of desire to talk outside of session versus blockage inside.
717. Well, it was uncomfortable 'cause it's like, well, here I am spending my money, I should be saying something, and then just--get that whole pressure thing building up in yourself--oh, I should say something, oh but I don't know what to say, and then you start going. . .you're concentrating so hard and the stress is so much there that all of a sudden everything goes.	Client feeling of discomfort and increasing pressure with silence results in continuance of blockage.	"Vicious" cycle: pressure to talk leads to increased blockage.

718. I noticed in the last few months, that he'll step in more now, the first while. . .when I'd come in and then all of sudden didn't want to say anything, he'd just sit there too, and wait for me, and I'd sit there, and. . .we'd sit there for like ten minutes and neither of us would say a word, but it usually worked 'cause then I'd get uncomfortable and then I'd say something.	Therapist intervenes less in response to client silence at the beginning of therapy; client's discomfort with silence leads to initiation of discussion.	Therapist's collusion with client's silence breaks the spell.
719. . . .it's like those uncomfortable silences. . .I'd be drumming my fingers, I'd be. . .looking around, and then finally I'd just get so antsy that I'd have to say something. Ultimately that worked, so then, you know, we'd start into it . . .	Client's discomfort with sitting in silence during session causes her to begin discussion.	Relief of client anxiety by ending the silence.
720. . . .and there are other times when it's like, oh, I don't know what to say. . .I don't know where to start, I don't know what to say, and then. . .I walk right in, it's like I have no idea what I. . .wanna talk about, I'm just too confused. . .we won't start talking, he'll just say, well, like how do you feel. . .we'll start with that, how do you feel, right this second, and then we kind of work our way back or forward or wherever I happen to be at that time.	Client confusion about what to discuss addressed by therapist's focus on client's current feelings.	Therapist approach to client blockage: start with here - and - now feelings.
721. . . .although it seems like now there's always something to talk about, or something I'm confused about or I don't get or I have a problem with. . .so usually I'm walking in there going, I don't get this. . .I feel more comfortable, now than I did. . .so that probably has a lot to do with it.	Client's increased comfort in therapy leads to initiative taken to begin discussion.	Less blockage results from greater comfort level.

722. . . .probably just the time, like it's been almost a year. . .I don't trust people that easily. . .I think, yah, it's just the time, and I still don't trust him completely--nothing he's done, but it's just. . .I still hold back a little bit.	Client identifies times as mediating variable to level of trust and degree of openness.	Increased client trust in therapist as a function of time.
723. Sometimes I can't pinpoint the feeling myself, I can't figure out what it is I'm feeling, I start thinking then, and then I can say what I'm thinking, and he says, no, what were you feeling. And then all of a sudden it's like, I don't know. . .all that I'm aware of is my thoughts, rather than what's in here.	Client becomes stuck when asked to identify feelings -- only aware of thoughts.	Therapist focus on client awareness of feelings leads to blockage.
724. . . .if we're stuck on something, it seems that when he says something that I find isn't true, then all of a sudden we just get going, and the words start flowing back and forth--for some reason that just triggers--like, no, it's not like that, it's like this.	Session becomes unstuck and begins to flow when client identifies a therapist statement as not true to her experience.	Blockage overcome: client recognition of incongruent interventions.
725. . . .another thing that's happened a few times that seems to really work without me even realizing it 'till afterwards--I'll come in, it's just like, oh, yah, I hate myself. . .I'm stupid. . .and he just sits there, well, yah. . .I guess you are, and so then I get mad, right, it's I am not! And that seems to do it too.	Client reacts to therapist's agreement with her self - denigration--results in resolving blockage.	Therapist's collusion with client's self blame activates anger, resolves blockage.
726. . . .I think he's starting to learn my personality a little bit too so he knows. . .kind of what buttons to push. Not in a bad way, but those seem to. . .my pride just starts getting in there, and it's like, no way! and, all of a sudden we settle down and start yacking.	Client feels therapist has matched his intervention style to her personality, which helps her become unstuck.	Pushing client's buttons shifts dynamic, ends blockage.

727. I'll talk about it. . .I start . . . analyzing it. . .in a very one-sided way. . .it's because. . .I'm this way and I'm that way and it's all my fault. . .he can't even get a word in edge wise. So then he'll. . .kind of like sarcastic. . .like, patronizing, and it's like, don't patronize me, and then, boom, we're in it and it's just kind of--cracks something in me.	Therapist's "sarcastic" approach to client's self blame allows her to overcome blockage.	Therapist alliance with client's critical side enables a reaction and resolution of blockage.
728. It's like in my gut, all of a sudden, no. . .that's not right and then all of a sudden I have to explain it, no this is the way, so that seems to help when I'm really stuck.	Client can become unstuck by correcting therapist's inaccurate paraphrase.	Unblocking through refutation of incongruent interventions.
729. Frustrating. Frustrating as hell. I sit there and I think, god, how come I can't. . .feel what I'm supposed to be feeling. . .or think or figure out what it is that I am feeling. . .usually when I'm blocked, I'm numb. . .like nothing, feel nothing, I can't--so then I just get frustrated and mad at myself 'cause I can't seem to get anywhere. And we try a bunch of different and. . .I don't know. . .some days it just doesn't come, nothing.	Client frustration, feelings of numbness, and of going nowhere when stuck in session.	Client frustration with the immobility of blockage.
730. That's right, yah, there's days when. . .just kind of sit there and somehow get through the session, I don't know, like half the time when I'm blocked, I really don't even remember most of the session just because it's--in my gut, I know that, it somehow it didn't click for me that day, so maybe I just kind of block it out 'cause then I don't usually remember too much of it.	Client is not always able to become unstuck; when blockage continues, client does not remember what occurred in session.	"Amnesia" for an unproductive, blocked session.

731. I felt kinda weird walking in just because . . . we got to a kind of a critical point last week, and it was really difficult and really hard and I had a hard time trying to accept what we'd gotten to. Ah, so the week was kind of weird and. . .I alternated from all kinds of different moods all week, and I know it had to do with what we had talked about, so I walked in today and I was just confused, and totally had no idea what I was feeling at all . . .	A turning point in previous session leads to changing moods in following week and confused feelings next session.	Two steps forward, one step back: progress leads to client retreat.
732. I was kinda blocked in. . .my feelings, like I couldn't quite pinpoint how I was feeling, whether it was sad or mad or. . .and I just couldn't quite get there--and we tried a different bunch of feelings on but, there was kind of jumble of them, so I was kind of blocked in that sense . . .	Client feels blocked in not being able to identify her current emotions.	Blockage in awareness of feelings.
733. . . .if I've had a good session. . .I don't feel good when I come out, often times I feel worse, but there's some part of me that does feel good, like, I guess, we've accomplished something or reached something or, I don't feel that today, I just feel, just as confused in a sense 'cause I don't really know exactly what happened today.	Client differentiates a "good" session from a "bad" one: good equals a sense of progress, bad equals confusion and "amnesia" for session.	Blockage results in a standstill in session, amnesia out of session.
734. . . .I'm sure that a lot of it is me 'cause it's really hard to face what we got to last week. . .I wanna face it but maybe somewhere subconsciously I don't so that's maybe why I'm kind of going back and forth and confused, so it was. . .just kind of a jumble today and it felt a little blocked at some times, at other times it felt clear, but then that would kinda muddy again . . .	Client struggles with blockage and the different parts of her which want to, and don't want to, face the difficult issues.	Inner battle over confrontation of difficult issues results in confusion and blockage.

735. . . .it seemed to work, 'cause basically. . .it rang a bell--that's how I was feeling coming in, I was mad and sad at the same time. . .one would come up, the other one would come up, it would be up and down all week--so that actually worked, I mean, it helped trigger something.	Therapist's use of metaphors helps client identify feelings and helps her to become unstuck.	Therapist technique intervenes in client's confusion and blockage.
736. . . .metaphors sometimes help just because it kind of removes it, in a sense, for me and then I can think about, even though it still is me I'm thinking about getting tied up in a rope, but it's nothing that's actually happening, so I find it easier to imagine it, and go from there, rather than to just walk in and go, ah!, I'm sad. . .I'm not that in touch with my feelings . . .	Therapist's use of metaphors matches client's process, in terms of separating the issue from her so that she deal with it outside of herself.	Therapist technique congruent with client process.
737. I have a hard time describing feelings, like often I don't know what they are, I can feel a feeling, I mean, but I don't know what it is. . .sometimes metaphors help just because I can imagine. . .I kinda try that on and see how it fits and it's like, yah. . .the feeling all of a sudden comes out, yah, I would be mad. Or if it wouldn't make me mad, then, no, that doesn't work, I kinda throw it away and we try something else.	Client has difficulty identifying her feelings -- metaphors help her to separate from and access the feelings.	Therapist technique allows client awareness of feelings from a safe distance.
738. . . .then I think I got a little scared and just kind of got confused then for the rest of the week, not really sure how to deal with. . .what the point we'd gotten to. . .I kinda take, as I said before, a few steps ahead and then. . .it's almost like an instinctive protection, I gotta take a step back again.	After client reaches a turning point, she becomes scared, confused and retreats as a protective mechanism.	Two steps forward, one step back: difficult turning point activates client's self-protection.

739. Lots of times I'll come in, and I know part of me wants to stop me. . .D. never stops me, but there's a part of me that often I'll put the brakes on, just like I'll stop myself without even realizing it, and I think that's when we have a problem with really blocking a lot because I just. . .don't know. . .if I should say. . .I'm still a little leery.	Blocks in therapy result when part of client wants to stop the process, "put the brakes on".	Self-protective part of client halts process, causes blockage.
740. . . .I definitely sense, like he wants to try and get me un-stuck at those times. . .and tries different ways . . . 'cause. . .when I'm stuck, I'm not any help, like I'll just sit there. . .he'll suggest something and I don't even say yes or no or whatever, I just go . . . (laughs). . .so we try different things.	Client perceives therapist as attempting to get her unstuck using various approaches; client sees self as non-responsive.	Therapist's efforts to intervene in client's blocked process.
741. But I. . .never sense that he gets frustrated. Ahm, usually when that happens, I get frustrated and then I start feeling bad because I think, oh, poor guy. . .I start thinking, oh, he's probably this, that and the other thing, he's probably going, jesus, would she just talk. . .but I never--even though, I'm thinking that, in all honesty, I've never once noticed any kind of. . .well hurry up, or any kind of frustration or anything like that on his part.	Even though client becomes frustrated and imagines therapist as same, when blockage occurs, she has no sense of frustration from him.	Client frustration with blockage and projection onto therapist.

742. Very patient. . .and caring. . .he doesn't, like, look frustrated, and oh god, and look at his watch, oh, when is she gonna get outta here. Also, that he doesn't give up, like when I'm being really stubborn and stupid, and. . .part of me really doesn't want to be here and that part is winning, and he won't give up, and there's another part of me that doesn't want him to, so. . .I'm glad that he doesn't give up, that's good. . .I just get the impression or the sense that he does wanna help me. . .to get better . . .	Client senses therapist's genuine desire to help and appreciates his alliance with the part of her which continues to struggle against blocks.	Perception of therapist alliance on side of client perseverance and improvement.
743. . . .it can do both, it has done both where I've been really. . .stuck, but maybe closer to some kind of truth than I realized and then I get in and then stuck, and we finally dig down into the feelings, and all of a sudden, it's like--oh, wait a second . . . something will just dawn on me and then, like something has triggered something, and then we start just rolling.	Client identifies one outcome of blockage is resolution and moving forward.	Two steps forward: blockage resolution results in progress.
744. . ..lots of times when I'm blocked, more often than not, I get frustrated, and the more frustrated I get, the more blocked I get, so then it makes it difficult.	Another, more frequent, outcome is that client's frustration and blockage "feed off each other".	One step back: client frustration interacts with, and maintains, blockage .
745. . . .so it can happen both ways, more depends on me. . .he can do the same things. . .on either of those two days, and depending on my level of frustration, I guess, or my mood or whatever, sometimes they'll work, sometimes it just doesn't . . .	Outcome of blockage depends on client's state of mind -- therapist's input does not determine outcome.	Blockage resolution or continuance solely dependent on client.

746. . . .when I get blocked, like not so much lately, but the first several months, it was almost like. . .I'd always think and feel all these things, and they'd be swirling around, but I just couldn't say them, like actually--I can verbalize it. . .sentence in my mind. . .and what I'm feeling and everything, but for some reason, when it came to actually say it out loud, that really bugged me, and I think a lot of the times when we'd get blocked, that would be a lot of the reason . . .	Client realizes that blockage, especially at beginning of therapy, results from inability to put thoughts and feelings into words.	Blockage as client inability to verbalize inner process.
747. That was a biggie. . .I have no idea whether it was, like I was too embarrassed to say it out loud or whether I didn't trust him, or often I always thought, well, if I say it out loud, it's true, right, so don't say it out loud. That contributed a lot to the blocking in the beginning.	Client inability to verbalize internal process due largely to fear that verbalization renders process true.	Client fear of externalizing inner process.
748. . . .those happened in the first several months more than now, and I think it was. . .just more of a trust issue. . .I know that he's not gonna hurt me, I know that he's not gonna tell anybody, I mean, logically, rationally, I knew all this, but there's something irrational, I couldn't tell him, so I just think, the longer I went, the more that kinda dissolved a bit . . .	Early blockages the result of client's "irrational" mistrust of therapist.	Dissolution of client's early irrational mistrust of therapist over time.
749. . . .but there's nothing that he could have done to gain my trust any faster than he did. . .I just knew right off the bat that I had to do on my own speed, and . . . .so we did talk about that, but it still took me a long time, like, there's nothing he could have done, I didn't really want him to do anything to like push his trust on me. . .just let me go at my own speed.	Client acknowledges own pace of building trust in therapist--does not want therapist to force the issue.	Importance of client pace in building trusting relationship with therapist.

750. . . .he does give me options, periodically. . .if he feels that perhaps we're really stuck, and we're just not getting over, he has suggested. . .maybe we could do a group, or maybe I could bring in another therapist. . .which is good, and he's always given me that option, but I've never taken any of them. . .I understand where he's coming from, in that sense that. . .if we're stuck. . .he's trying to do his best at--try and get us un-stuck, I'm very adamant about it. . .no, I don't wanna do any of that stuff, but I mean, I gotta give the guy credit, well at least he asked . . .	Client refuses therapist's other options for getting therapy unstuck, although she appreciates his rationale and attempts.	Appreciation of therapist's various efforts to unblock therapy.